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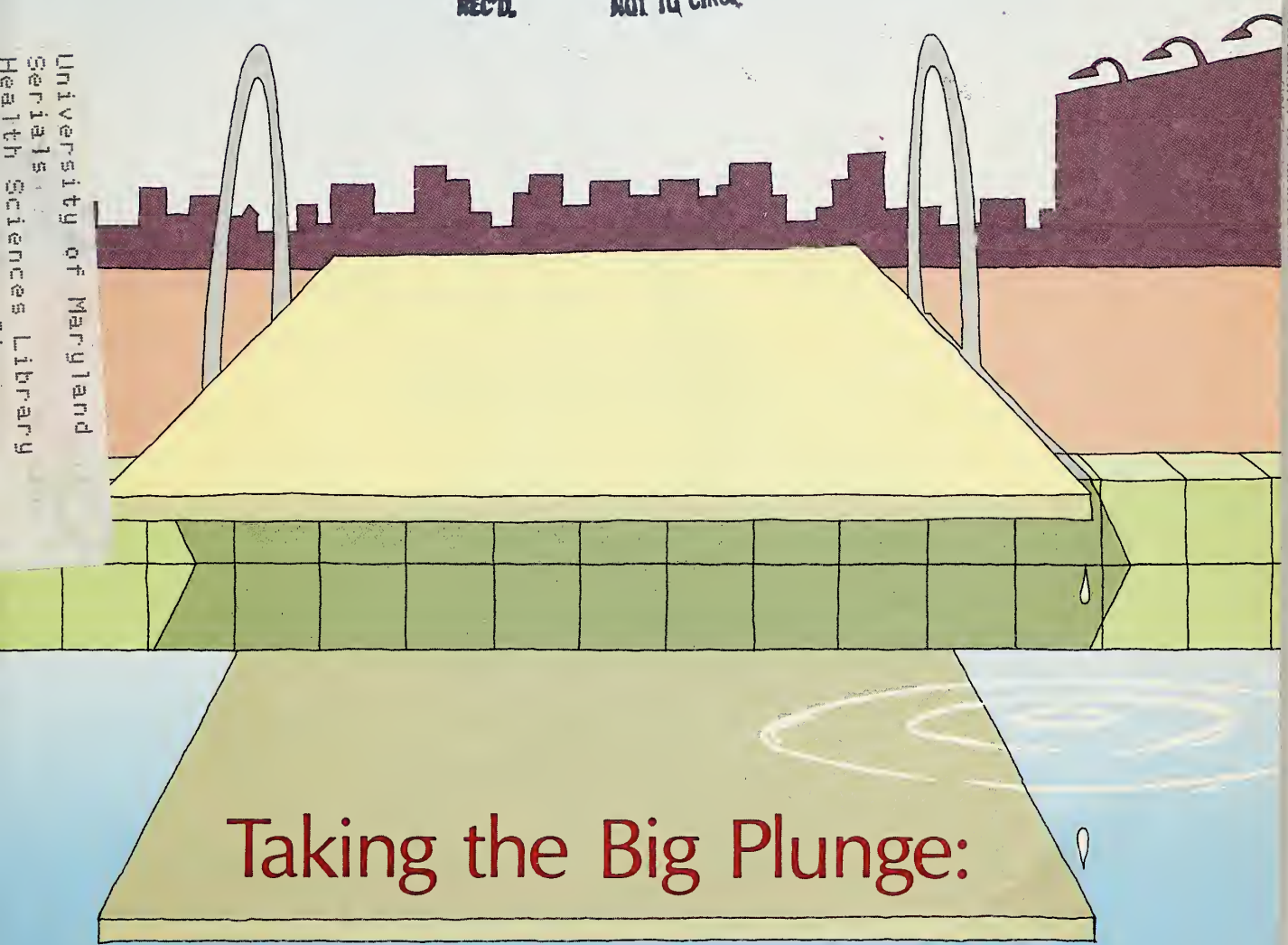
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Taking the Big Plunge:

Is Physician Marketing a Sink-or-Swim Proposition?



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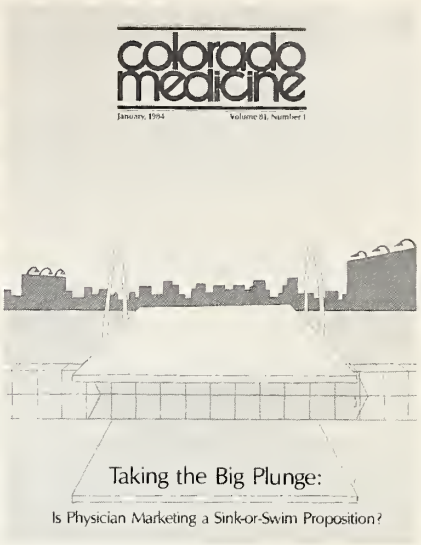
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Cover Description

"Taking the Big Plunge." Is physician marketing a "sink or swim" proposition? The theme of our January magazine is competition. According to the AMA Department of Practice Management, private practice physicians are facing a lot of competition, due to many factors, including a growing surplus of physicians, burgeoning government regulations and alternative forms of health care. Physicians must learn to market their practices in order to survive, says the AMA. See the article, "AMA Gives Economic Swimming Lessons," p. 13.

PPOs, HMOs, IPAs all provide competition to private practice physicians. What is a PPO? Are PPOs a boon or bane to physicians? See the first in a two-part series of articles on PPOs in Colorado, p. 15.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

Physician's Advocate

Who is your advocate? Who goes to bat for you on legislative, social, economic, political and public information issues? Your national, state, local and specialty medical societies. Very few other organizations or people take the physicians' part these days. Adversaries are legion. This makes it imperative that our organizations become stronger, closely allied and increase active membership.

Recent court decisions involving the Michigan Medical Society and the Federal Trade Commission established that your medical societies cannot set fees, write or negotiate contracts or establish any organization that causes restraint of trade. However, this court case established quite firmly that the medical society can continue to be the physicians' advocate, which is the position that the Colorado Medical Society and its components will continue to pursue for you as vigorously as possible.

What has been done in the physicians' interests?

- National lobbying efforts helped postpone the Rostenskowski proposal, which would have frozen physicians' Medicare fees and mandated assignment of physicians' services, with criminal penalties among the enforcement provisions.
- A strong lobbying effort was mounted against the federal "Baby Doe" rules and regulations. These rules would take decision-making authority away from parents and physicians of infants with life-threatening impairments.
- Locally, the CMS Council on Legislation is researching and reviewing the bills to be introduced into the state legislature in the 1984 session so that they may support those bills which are favorable to your practice and oppose those that are not.
- A hospital medical staff section was established at the annual meeting in Tamarron. Many issues affect hospital medical staffs in our changing environment, including the new prospective payment system.
- Practice management seminars have been conducted.

What is being planned?

- Nationally, the AMA will continue to lobby the U.S. Congress in your interests. You can assist these efforts by joining AMPAC/COMPAC and supporting those national legislators who support medicine.
- At the state level, the Council on Legislation is planning a "get out to vote" campaign and is making year-round contacts with legislators. "Keyman" programs will be increased in an attempt to involve medical society members and their families in as many campaigns as possible this fall.
- The Council on Socio-Economics will get out more information on alternative health care delivery systems.
- The Council on Professional Relations and Medical Service will hold a forum for legislators on rural health issues.
- The street drug problem and constructive programs to approach this problem is on the agenda of the Council on Public Health.
- The Colorado Medical Society is also moving into a leadership role with the many alternative health care delivery systems, such as HMOs, IPAs and PPOs in Colorado. An attempt is being made to organize these systems into a statewide network which will be able to compete among themselves, but in a constructive manner which will benefit both you and your patients. Components of this network will include a statewide patient entry system, data collection, peer review and benefits.
- CMS is working for a competitive health care delivery system and opposes a system based on the public utility concept. One of our efforts includes our contribution to the Colorado Health Forum, composed of representatives from business, labor, the insurance industry, hospitals and consumers. The forum is also aimed at preserving a competitive system.

> Adversaries to medicine are legion.

Your national, state and local societies are your advocates and plan to expand their efforts for you. To be even more effective, they need your help. Plan to give a little more of your time, ideas and money to support your societies this year.

Quasi-medical groups are gaining more privileges in licensure, medical practice, hospital privileges and authorized fees for service. They will continue their efforts. You must be organized and willing to contribute your part in order to retain your rights and privileges, as well as to maintain the high quality of care that American medicine has come to represent.

Competition and the Changing Role of Medical Societies

ama update



Joseph L. Kovarik, MD
CMS Delegate to the American Medical Association

The AMA Update is a series of editorial columns written at the request of the Colorado Medical Society by the CMS delegates to the American Medical Association. The articles represent the opinions of the authors and do not necessarily reflect the official viewpoints of CMS or the AMA.

Originally, medical societies were organized to foster the interests of member physicians and the patients they serve. In the past such societies provided their members with professional and ethical guidelines and continuing medical education. The entry into the health system by a patient was usually through an individual physician who would then supervise or administer a specific course of treatment. Medical societies were organized on a geographic basis with the various competing individual physicians as members. Most of these geographic organizations were on a county-wide basis and were then linked as component units into state medical associations. In turn, these associations were components of the national organization, the American Medical Association.

In addition to focusing attention on the care and welfare of individual private patients, medical societies assumed public health roles at both the county and state levels in programs which provided medical care for indigent people through public hospitals and clinics, immunization programs, public health education, etc. The corporate practice of medicine was frowned upon and indeed was illegal in most states.

During recent years the traditional role of the medical society in its relationship with its members has been undergoing a dramatic change and is still evolving. No longer are medical societies the chief resource for continuing medical education, as this function has been largely taken over by professional societies and hospitals. Government influence is affecting some of the long-standing functions of the medical societies, such as fee review and grievance committee activities. These activities have been abandoned in many areas because of fear of intervention by the Federal Trade Commission.

The biggest change the medical societies must address, however, comes from social and economic forces which are rapidly changing the methods of administering and paying for medical care. Much of this change has been fostered by a coalition of business and industry, who have become increasingly concerned about the rising cost of health care and have fostered the development of HMOs, IPAs and PPOs.

While some may question whether such organizations actually do provide quality medical care at less cost, the fact that they are becoming a significant force is obvious. Currently there are 11 HMOs, IPAs or PPOs in the state of Colorado, while nationally, HMOs represent approximately seven percent of all patients with hospital insurance. Competition is frequently fierce among these provider organizations, and as the number of patients they enroll increases there is a resulting shrinking patient supply for physicians who are not allied with such organizations. Many physicians undoubtedly will opt to join one or more provider groups, although reluctantly, in order to survive.

> More and more physicians will accept salaried positions with a group, clinic or hospital.

Another important factor in this equation is the emergence of for-profit hospitals. Of the 6,900 general hospitals in the United States today, almost one out of five is either owned or managed by a profit-making organization. This includes at least one university hospital, the University of Louisville's new medical center. This trend may significantly alter the traditional relationship of the medical staff to the hospital administration. In some areas the hospital medical staffs are closed and on salary.

The influence of the hospital on the practicing physician is also exemplified by the fact that there are some 400,000 practicing physicians in the United States and approximately 90,000 already have some contractual relationship with a hospital. Many of these are relatively minor, such as EKG readers, but there is a proliferation of part-time and full-time positions which are filled in hospital emergency rooms, intensive care units, cardiovascular and GI laboratories, plus departments of anesthesia, pathology and radiology.

My prediction for the future is that more and more physicians will be participants in a provider organization which will offer prepaid (perhaps capitation) discount fee schedules and that competition among these organizations will increase significantly in the next few years. More and more physicians will accept salaried positions with a group, clinic or hospital in return for benefits such as guaranteed patient

volume, malpractice and health insurance, vacations and educational benefits. Once we have allied ourselves with one or more of these provider groups, the era of the physician as a private entrepreneur will be over. There will be few patients who are not committed to a specific plan purchased through their company or union.

After we have been organized into these convenient groups, I believe the next step will be a consolidation of the HMOs, IPAs, PPOs and for-profit hospitals into several large health care organizations. These corporations will in turn provide for inpatient care, outpatient care, rehabilitation, home services, etc. and will market these services through their own insurance companies or marketing resources.

The next plausible sequence will be for several (perhaps six) multinational corporations to then take over this newly-organized health industry (so that IBM, for example, might purchase Humana, and General Motors might purchase Hospital Corporation of America) and operate them as the health care division of their diverse corporate activities. Each one of these giant corporations will then own and operate 1,000 hospitals throughout the country with all health provider personnel on a salaried basis. If this comes to pass, this will mean that IBM, for example, or another such multinational, will be able to hire, fire and assign physicians to specific duties and geographic areas just as they currently deal with engineers, systems operators, etc. The physician, in this scenario, will remain a professional in the health field, but will be able to negotiate only for wages, hours and fringe benefits.

While the possibility of such an evolution in the provision of health care is not pleasant to those of us who have enjoyed independent private practice, ths does not mean that it might not be attractive to medical students and residents in training who have not shared our perspective. The prospect of finishing a training program and being offered $50,000 a year with no malpractice or office overhead expenses to worry about, and with vacations, educational opportunities and other fringe benefits provided, might not seem at all unattractive. In this type of salaried employment, these new physicians will also have an immediate patient supply and will not have to worry about struggling to build up a practice.

What does all of this have to do with medical societies? First, medical societies will have to consider reorganizing their base units of participation from the individual physician to the various groups to which the physicians are pledging their professional and financial allegiance. The AMA and some state and local societies have already recognized this fact by granting delegate status to hospital staff organizations, in addition to the traditional component society delegates. The American Group Practice Association, which represents 300 medical group practices with 14,000 physicians throughout the country has requested observer status in the House of Delegates and a request for delegate status may not be far in the future.

Because most patients will seek entry into the health delivery system through an organization or hospital, rather than through a private physician, the competition among these various groups can be expected to escalate. Already intense advertising, including newspaper and magazine ads, yellow pages of phone books, large billboards on streets and highways, and even radio and television promotions, can be seen throughout the country. As these provider groups mature it is apparent that they will take one or two forms. Either the hospitals will hire or contract with specific provider organizations and perhaps have physicians on salary, or physicians may organize their own group and in turn contract with specific hospitals to use their facilities. The Mayo Clinic is an outstanding example of this kind of relationship in which a medical practice group contracts with hospitals.

The medical society will become a common meeting place for these various organizations to discuss common goals and problems. The California Medical Association has a new Department of Contract Evaluation and Negotiating Services which functions as a clearing house on PPOs and contracting in general. This special unit has prepared a handbook listing 38 questions a physician should ask before joining a PPO or signing any other contract for the provision of professional services.

It seems reasonable that the medical society continue its role in setting and enforcing standards and ethics in the professional arena as well as providing a liaison with government organizations and programs, such as the FTC, Medicare, Medicaid, etc. at the national level. At the state level the medical society can provide a forum for hospital staffs and/or health organizations for deliberation of common issues and concerns, including such questions as possible participation in the provision of indigent care with local governments, state and county health department issues regarding specific projects, or public health in general. The same role can be envisioned at the county society level, especially since some county societies, such as Denver Medical Society, are attempting to organize into IPAs and PPOs.

Whether we as individual physicians will have a significant impact on our future professional activities is a sobering question. If so, it is apparent that we will have to voice our concerns through an organized cooperative effort. Our individual opinions and efforts will be futile.

We can only hope that organized medicine, exemplified by our medical societies, will be able to meet these challenges in a prudent and timely manner. It is imperative that we join, support and participate in our medical societies in order to retain some influence over the future of our profession and our professional obligations to the public we serve.

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New Rules and Regulations for Physicians' Assistants

the lobby

M. Robert Yakely, MD, Chairman, Council on Legislation
Carol Tempest, Director, Division of Government Affairs

New rules and regulations for practice of certified physician assistants and for the direction and supervision of non-physician health care providers have been adapted by the Board of Medical Examiners (BME). The rules apply to all licensed MD and DO physicians who have persons rendering direct health care services under the physician's personal and responsible direction and supervision. Thus, it is important that you be aware of the changes. The following is a list of the major provisions:

1. Persons covered include licensed non-physician health care providers who are practicing beyond the scope of practice permitted by their license and unlicensed non-physician health care providers who are rendering medical services other than carrying out simple, routine physician orders.

2. Physicians supervising such persons must file with the BME, within 30 days of employment, the information required on forms required by the board. The board must also be notified of termination of such supervised persons.

3. Direction and supervision of such non-physician providers must be rendered by a physician personally and not through intermediaries, and the physician is responsible for assuring that the delegated services are performed with a degree of care and skill that would be expected of the physician.

4. The physician must provide appropriate direction to the non-physician provider. When oral directions are utilized, the physician must confirm those directions in writing on the patient's chart and assure that they are being or have been properly carried out.

5. There is a presumption that the supervising physician shall routinely be present at the location where the non-physician provider practices. Where on-site supervision is not provided, the burden shall be on the physician and/or the non-physician provider to establish that the lack of such supervision was reasonable under the circumstances. Specific exemption from this presumption is made for facilities operated by the state Departments of Institutions and Corrections.

There shall also be a presumption that a designated supervising physician cannot adequately supervise more than two non-physician providers at one time, and it shall be the burden of the physician to establish the contrary to the board under said physician's particular circumstances. The physician must review the quality of medical services rendered by such non-physician providers every two working days by reviewing medical records to assure compliance with the physician's directions.

6. The supervising physician must assure that the non-physician provider is identified to his or her patients by the wearing of an identification badge setting forth his or her name and non-abbreviated title.

Rules for practice by certified physician assistants contain the same language as items 1 through 6 with an additional section concerning prescription and dispensing of drugs:

A. No controlled substances shall be prescribed by a certified physician assistant.

B. A certified physician assistant may issue a prescription order for any non-controlled substance so long as:

1. The supervising physician has issued written protocols specifying

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which non-controlled substances he uses in his practice and which may be prescribed by the PA on both a case-by-case and per patient visit basis. For purposes of this rule, "written protocol on a case-by-case basis" means instructions for prescribing by a PA for a new patient or a returning patient who presents new, different or additional signs or symptoms from those previously diagnosed and treated. For purposes of this rule, "written protocol on a per patient visit basis" means instructions for prescribing or refilling a prescription by a PA when a patient returns with recurrent signs of symptoms which have been previously diagnosed.

2. The order is written, not verbal.

3. Each and every prescription and refill order is entered on the patient's chart and countersigned and dated by the supervising physician within one week.

4. Each written prescription order shall be on the supervising physician's prescription order form and signed by the PA and shall contain in printed form the name, address and telephone number of the supervising physician and the name of the PA. In addition, the PA shall handwrite the name of the supervising physician on the prescription order form.

C. All drugs dispensed or administered by PAs to third parties shall be prepackaged in a unit-of-use package by the supervising physician, or by a pharmacist acting on the written order of the supervising physician, and shall be labeled to show the name of the supervising physician and the PA.

D. PAs shall not write or sign prescriptions or perform any services which the supervising physician is not qualified or authorized to prescribe or perform.

E. No drug which a PA is authorized to prescribe, dispense, administer or deliver shall be obtained by said PA from a source other than a supervising physician or a pharmacist.

F. No device which a PA is authorized to dispense, administer or deliver shall be obtained by a PA from a source other than a supervising physician or a pharmacist.

Ronald E. Tegtmeier, MD

Marketing in Medicine

Reprinted by permission from the ***Clear Creek Valley Medical Society Newsletter,*** *November 1, 1983*

Marketing medical practices has become a reality in the competitive medical world today. Many physicians misunderstand marketing concepts and consider them synonymous with advertising. Therefore, they disregard the possibility of using marketing techniques to enhance their practices.

There are significant differences between marketing and advertising. Marketing is basically an attempt to understand the community's needs and then position one's self or practice to fill these needs. On the other hand, advertising is an attempt to sell a product that often is already available. At times, this involves creating an artificial need for the product in order to sell it.

I think that most of us do not want to see the widespread use of advertising in medicine. However, marketing is used very effectively by hospitals and corporations which are involved in medicine. Today, if a physician wishes to maintain his practice, he will have to understand and use marketing methods.

According to our recent questionnaire, a significant percentage of our members already use marketing techniques. For example, 8 percent have developed a patient newsletter; 24 percent have studied demographic information about the community and the effect of these demographics on their practices; 7 percent have developed a written marketing plan for their practices and 20 percent have used surveys to learn about patient satisfaction with their practices. It is interesting to note that some physicians have also used advertising. Eight percent have advertised their practices on radio, TV, newspapers and/or magazines and 7 percent have employed an advertising or public relations firm or consultant.

Other parts of the questionnaire illuminate the importance of developing marketing information for our members. Fifty-six percent of our members see their patient loads decreasing or remaining the same; 38 percent see their gross income decreasing or remaining the same; 62 percent see their net income decreasing or remaining the same; 44 percent feel that competition in our geographic area is too high and 87 percent feel that there are too many doctors in our area.

Marketing techniques have proven to be effective in reversing some of these discouraging statistics. These techniques are an ethical means of developing and increasing one's practice.

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Reviewed by Frederic W. Platt, MD

The Social Transformation of American Medicine

Author: Paul Starr
Basic Books, Inc., New York City, 1982. 449 pages. $24.95

Paul Starr, a social historian at Harvard, has written a history of United States medicine and the medical industry. Contending that "The dream of reason (medicine as a liberating science) did not take power into account," Mr. Starr has written a book about power. Some physicians believe that the medical profession ought not concern itself with political phenomena and readers of that persuasion should avoid this book. Those who wonder what combinations of influences led us to where we are and what is likely to happen next should read it. It is not an easy evening's read, but will repay study with thought-provoking information about the structure of our profession.

All professionals, including physicians, have sought authority. Mr. Starr describes the development of the great authority of contemporary medicine over the last two centuries. He shows how it has been buttressed by dependency and legitimacy. The dependency of our patients on their physicians was strengthened by our control over hospitalization, our gatekeeping and certifying functions (How often do you have to sign notes certifying that an adult patient was ill last week and now can return to work?) and payment systems that allow payments to physicians but exclude other "health providers."

The author explains that our professional authority was legitimized collegially, i.e. by a community of our peers who validate our competence and knowledge, cognitively by the existence of rational scientific grounds for our practice and morally, by our pursuit of a substantive value external to ourselves, the health of our patients. Have you, like me, felt gratitude for the seeming unwarranted trust that your patients had in you, short of their being given any data to support that trust? When a patient says "you're the doctor" and thereby accepts your judgment as he wouldn't with an electrician or a plumber, you are benefiting from professional authority dedveloped over centuries.

One encounters fascinating historical nuggets in this book. Did you know that an 1870 English study showed in-hospital mortality for surgery to be greater than the mortality for the same operations performed at the patient's home? That physicians just prior to 1900 saw an average of five patients a day, usually at the patient's home, and that much of the physician's time was spent traveling to and fro? That the main reasons for the enormous expansion of the medical market around 1900 were the development of the telephone, automobiles and hard roads?

Did you know that national health insurance seemed a shoo-in just prior to 1917 but was defeated by a strange confluence of events? First, we entered the war in Europe with an enormous surge of anti-German feeling. That negative feeling extended to all things German, including socialized medicine, one of Bismarck's inventions. Second, Samuel Gompers, president of the American Federation of Labor, saw compulsory health insurance as an intrusion on the power of the union. If the union could provide health benefits to its members, its power would be strengthened. If the federal government were to do so, the union would lose power. Third, the insurance industry saw compulsory health insurance as a threat to their well-developed funeral insurance program, since federal programs had been designed to include burial expenses.

The author's primary point of view is economic. He does provide scientific and moral explanations for changes in the medical industry, but his most compelling arguments are usually economic. These arguments are quite enticing. For example, he quotes Adam Smith to explain the growth of specialization in any field: "The division of labor varies according to the extent of the market. As the market expands...the specialist typically gives up those services offering the lowest return and concentrates on those offering the highest. In medicine, these are often services performed in hospitals because of the indirect savings in time to the physician and the standard of higher fees for procedures that are or were at one time complex." That analysis led me to fantasize a cocktail party dialogue. A guest says "Ah, you're a doctor. What do you specialize in?" To which the doctor then replies "I specialize in the services that offer the highest return."

Some of Starr's definitions are treasures. "A quack is a physician who pleases his patients more and his colleagues less." Or "Differing theories of equity give rise to differing schemes of medical insurance." The social theory of equity suggests that the entire society should bear the burden of insuring the health of its members. This, of course, puts an unearned burden on the healthy to support the sick. The community theory of equity would limit sharing of responsibility among a single community. Group-based equity allows healthier groups to escape without the cost of caring for the less healthy. But such group equity forces the cost for the least healthy to be intolerably high.

Some of his ideas are more complex. For example, "Physicians have benefited from socialization of

(Continued on p. 24)

Practice Management Workshops Prove Successful

Six "mini-workshops" in medical office practice management, presented by nationally known Conomikes Associates, Inc. and sponsored by the Colorado Medical Society, were conducted at the University of Colorado School of Medicine November 8-11, 1983. Five half-day workshops, covering such topics as Better Collections, Billing and Insurance Methods, Reception and Patient Flow Techniques, Personnel Management, Personnel Communications and Leadership and Practice Development Techniques attracted a total of 146 registrations, including some people attending more than one workshop. A one-day workshop on Computers in Medical Practice brought in 15 more participants. These numbers ensured that the Colorado Medical Society realized "non-dues revenue" from these programs.

More important than the numbers, though, was the excellence of the programs. Judging by the response of the group and data from the evaluation forms, virtually all agreed that the workshops were most worthwhile and directly relevant to the day-to-day concerns of active medical practices. One slight disappointment was the relatively low ratio of physicians to office workers in attendance, a problem that may be diminished in the future by offering CME credit and by even stronger promotion.

CMS will sponsor a 1½ day Conomikes workshop, "Introduction to Medical Practice," April 5-6, 1984. This program, successfully conducted in Colorado for several years, is geared to the needs of 3rd and 4th year residents, especially those just getting ready to set up practice and to doctors in practice for six months or less. It helps new doctors get off on the right foot in all of the "business aspects" of medical practice.

Update on Scientific Program

Participants at the 1983 Scientific Program in Tamarron were treated to an impressive array of stimulating speakers and challenging topics, ranging from future concerns to the latest clinical advances, and including both down-to-earth topics with immediate applicability and mind-stretching philosophical, and often controversial, issues. Measured by sign-ups for CME credit, attendance exceeded 300 (including "repeaters"); actually, though, total attendance was much higher if you also count all those, including non-physicians, who didn't sign up. Dr. Cruse's provocative presentation on the Alcoholic Physician, sponsored by the CMS Auxiliary, packed the hall; probably more than 200 attended this program.

Dr. Arnold Greensher, program planning chairman, and his committee certainly deserve the lion's share of the credit for such an outstanding event. Dr. Greensher, happily, will be the planning chairman again for this year — so you can look forward to even greater things! Hope to see many of you there.

Denver Medical Books

A new book-ordering service, Denver Medical Books, opened this fall at the Denver Medical Library, 1601 E. 19th Avenue in Denver. The facility supplies books in the fields of medicine, nursing, allied health, dentistry, veterinary sciences, hospital administration and related fields.

Books can be ordered by telephone, 839-6670; in person, by visiting the library during office hours (8-5 Monday through Friday and 9-1 Saturday); in person, from the Colorado Medical Society, during office hours, 8:30-5:00 Monday through Friday; or through hospital librarians throughout the metropolitan Denver area.

Customers will receive most books within two weeks. Orders may be picked up at the Denver Medical Library or the Colorado Medical Society. When requested, Denver Medical Books can arrange delivery to any area hospital. Books can also be mailed directly to the customer.

Other services of Denver Medical Books include information on the latest texts in all fields of the health sciences, assistance in developing a professional library and a search service for out-of-print medical and nursing titles. Files of current reviews and in many instances copies of recently published books are available at the Denver Medical Library.

CFMC Plans Regional Conferences on DRGs

The Colorado Foundation for Medical Care will sponsor a series of three regional workshops to educate Colorado physicians about the impact of Medicare's new prospective pricing system (PPS) upon their practices. The seminars will also acquaint doctors with the Foundation's role in the review process mandated under the diagnosis related group (DRG) based system.

Each session will consist of presentations by physicians and CFMC staff who will discuss the origin and implementation of the PPS, the methodology by which DRGs are calculated, and case-studies detailing potential impacts of the new system on physicians' medical decision making. The case studies will also highlight the review functions that CFMC will assume as the Professional Review Organization (PRO) for Colorado.

The schedule for each workshop is provided below. There are no costs to Colorado physicians wishing to attend the workshops.

Denver, Colorado
Cherry Creek Inn
600 S. Colorado Blvd., Conifer Room
January 23, 1984
6:30 p.m. to 9:30 p.m.

Pueblo, Colorado
Holiday Inn, 4001 N. Elizabeth
Room A
February 23, 1984
6:30 p.m. to 9:30 p.m.

Grand Junction, Colorado
Roadway Inn
2790 Crossroad Boulevard
January 19, 1984
6:30 p.m. to 9:30 p.m.

Loveland, Colorado
Coach House
Junction I-25 and Hwy 34
January 17, 1984
6:30 p.m. to 9:30 p.m.

Colorado Springs
Satellite, 411 Lakewood Circle
Gold Room
February 22, 1984
6:30 p.m. to 9:30 p.m.

For further information, contact Joanna Rowe, 321-8642, Ext. 312.

Child Seat Restraints

by Phil Lewis, MD

In June of this year, Governor Richard Lamm signed House Bill 1070 which requires all children in Colorado four years and under and less than forty pounds to be restrained in a federally-approved child safety seat while riding in a motor vehicle. With the signing of this bill Colorado became the 34th state to enact this type of legislation.

Automobile accidents, in which children are the occupants of motor vehicles, are the leading cause of death in children over six months of age. Every year in the United States more than 2,000 children are killed in auto accidents and tens of thousands are seriously injured. Child safety seats have been conclusively proven to be 90 percent effective in preventing deaths and approximately 85 percent effective in preventing serious injury.

In 1974, Tennessee was the first state

to require all children to be transported in child safety seats. Tennessee experienced a 50 percent reduction in traffic deaths the first year the law was on the books and a 75 percent reduction the second year. Sixteen states, including Colorado, have passed child restraint laws this year.

The passage of this legislation in Colorado has been the culmination of a three-year endeavor. Bills introduced into the state legislation during the past two years have failed to be enacted. Approximately one year ago, a number of organizations joined forces to work for the passage of child safety seat laws in Colorado. This group was known as the Colorado Coalition for Child Passenger Safety Legislation and consisted of representatives from the American Academy of Pediatrics, Red Cross, AAA, the Motor Vehicle Manufacturers Association, Children's Hospital, Colorado Division of Highway Safety, Colorado Developmental Disabilities Council, Colorado Safety Association, the Colorado State Patrol, Western Insurance Information Service, Colorado Highway Users Conference, Colorado Nurses Association and the Colorado Medical Society. I was very privileged to chair this organization. All the numerous members worked diligently and selflessly putting in untold number of hours. The work of this coalition contributed greatly to the passage of House Bill 1070.

The real success of the passage of Colorado child restraint legislation should, however, be attibuted to the expert and skilled leadership of Representative Bill Artist of Greeley and Senator Ted Strickland of Westminster. These two dedicated and hardworking legislators were able to persuade the majority of their colleagues to vote for this bill so that at the final count two-thirds of the lawmakers voted for House Bill 1070.

Today we immunize children against seven diseases: measles, mumps, rubella, diptheria, tetanus, whooping cough, and polio. Because of wide acceptance of these immunizations there are fewer than a hundred deaths from these seven diseases in the United States every year. It is our hope that the child safety seat will be equally well accepted and become the "eighth immunization."

Placement Service Available to Anesthesiologists

As a service to physicians and hospitals, the Colorado Society of Anesthesiologists will respond to correspondence from anesthesiologists looking for practice opportunities in Colorado and try to match them with hospitals needing such staff. Carter Ballinger, MD, is the Placement Chairman for the society.

The service is free to hospitals and physicians. For more information, Dr. Ballinger can be reached at (303) 394-8276 or at home, 321-4952. Address correspondence to Dr. Carter Ballinger, 4200 E. 9th Avenue, Box B-113, Denver, Colorado 80262.

Upcoming Meetings for Board of Medical Examiners

The BME is scheduled to meet on January 12 and April 12, 1984. Individuals interested in providing testimony at these meetings are encouraged to contact the CMS Government Affairs Division at 321-8590, ext. 213. We urge your cooperation in this matter so that CMS may successfully coordinate its political effectiveness efforts.

Medical School Offers Consultation on Admissions

Dr. Henry Silver, Associate Dean for Admissions at the University of Colorado School of Medicine, recently wrote to the Colorado Medical Society that he is willing to discuss the admissions process to the medical school with any CMS member whose child has applied to the school.

In his letter Dr. Silver stated, "I welcome phone calls from any parent who wishes to speak with me about any aspect of their son's or daughter's desire to be a physician and their interest to gain admission to this medical school. They may call me before their son or daughter applies, while the admissions process is underway, or after a decision has been made."

Dr. Silver's phone number at the medical school is (303) 394-7361.

Hyperbaric Oxygen Therapy Introduced in Denver

On November 2, at Porter Hospital, a Littleton man became the first patient in Denver to receive a hyperbaric oxygen treatment. Hyperbaric oxygen therapy, in which a patient breathes 100 percent oxygen in a pressurized chamber, is beneficial for many emergency and long-term medical conditions, according to Dr. Jim Huber, medical director of the new service. These conditions include radiation necrosis of bone and soft tissue; decompression sickness, acute carbon monoxide poisoning and gas embolisms.

Physicians, respiratory therapists and emergency nurses at Porter Hospital have received special training in hyperbaric oxygen therapy and will provide service 24 hours a day. For further information, contact Porter Hospital at 778-5724.

Subscriber Drug Alert Bulletin: Folk Remedies

Lead poisoning in children, attributable to folk remedies, appears to be increasing. Azarcon or Greta, a purported digestive agent, was first associated with lead poisoning in 1981. Since that time, 14 additional cases have been reported to the Centers for Disease Control. Azarcon and its related remedy, Greta, is a yellow to orange powder used primarily by some Hispanics. Some formulations have been show to be almost pure lead tetroxide (70 to greater than 90 percent lead). Other gastrointestinal remedies may contain metallic mercury.

These preparations are used to treat empacho (a stomach disorder) in infants. This product has also been sold as Rueda, Corral, Alarcon, Liga or Maria Luisa in herb shops and through folk healers on both sides of the Mexican-American border. A recent report from the CDC indicated that a survey done in Colorado in June-September 1982 showed that seven percent of 100 migrant children under the age of 12 had been treated with Azarcon or Greta at some time for gastrointestinal illness.

Use of these types of products is not limited to the Hispanic population. Recently, lead poisoning has been documented among Hmong refugees from Northern Laos living in St. Paul, Minnesota. A Hmong folk remedy, generally referred to as "pay-loo-ah," consists of red and orange powders. It is believed to have originated in China or Southeast Asia and is given to children for fever or rash. Two samples of remedies obtained from Hmong households were found to contain lead (one to 90 percent); three samples contained arsenic in concentrations of 70 to 80 percent. These remedies are widely available through Asian food stores or among peddlers.

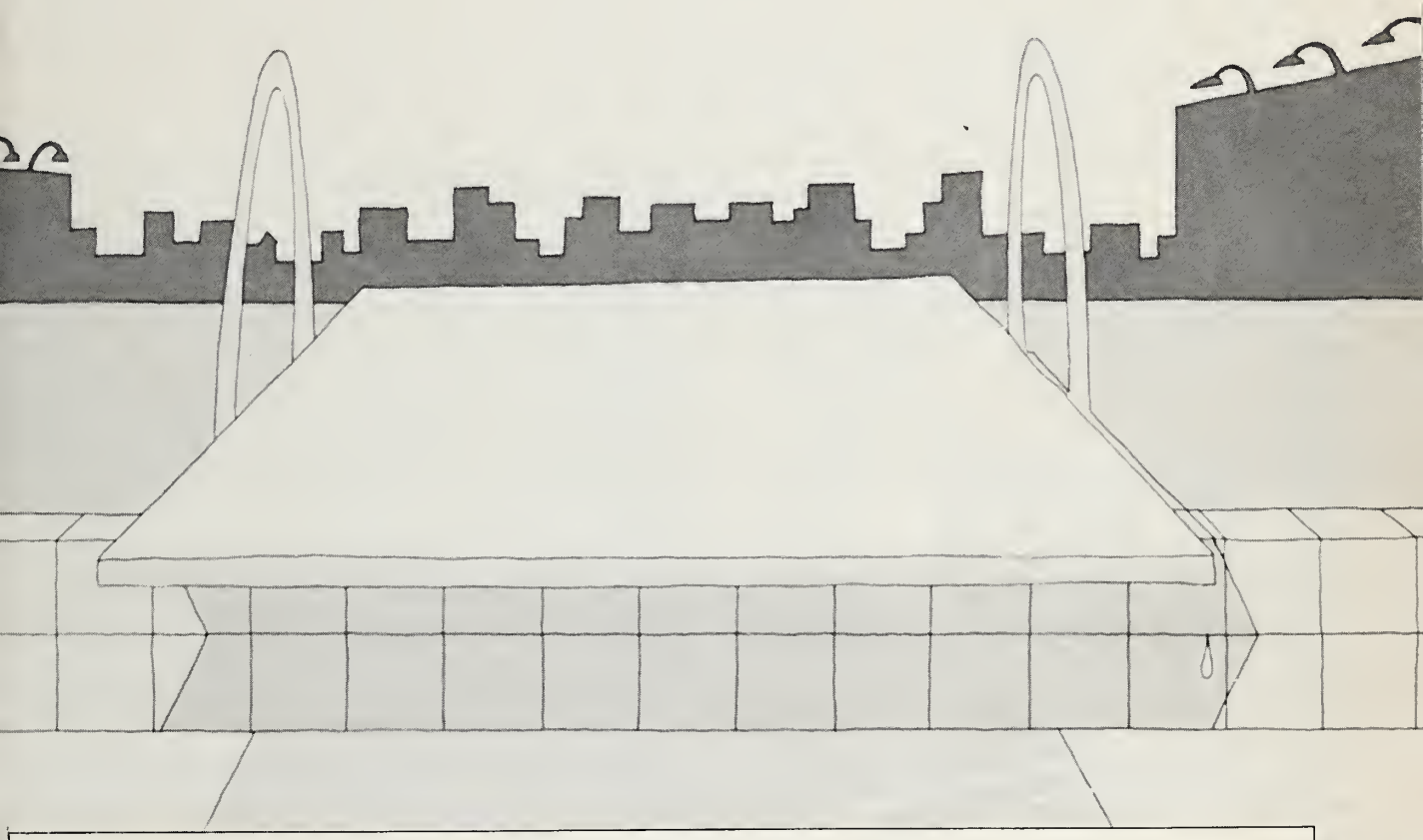
The Centers for Disease Control recomend routine erythrocyte protoporphyrin (EP) screening for all children between six months and five years of age. An EP level over 50 ug/di indicates either iron deficiency anemia or lead toxicity. Lead toxicity should then be confirmed by a blood level. Information on patient management and/or reporting of cases may be obtained by calling the Rocky Mountain Drug Consultation Center; in Denver, 893-DRUG; outside Denver but within Colorado, call toll-free 800-332-6475.

Is the private fee-for-service physician likely to become extinct? What many analysts refer to as the "last of the cottage industries" — the private practice of medicine — is facing stiff challenges in the future. These challenges include a surplus of physicians, competition from other health care providers, such as nurse practitioners, and a number of new health care delivery systems, such as IPAs, PPOs and HMOs. What are the choices for private physicians? What do all these initials mean and what will they do to the private practice of medicine?

According to an article by Christine A. Hinz in the *American Medical News* (August 12, 1983), based on current AMA statistics, physicians will be based with some rather grim facts in the not-distant future:

- The 1980 Graduate Medical Education National Advisory Report says that there will be 70,000 excess physicians.
- Fewer than half of all private physicians have experienced an increase in patient loads.
- Seventeen percent have reported that their income is decreasing.
- Patients today are better-educated, more cost-conscious and as a result, more willing to shop around for medical care.
- Group practices will have a competitive edge over private physicians.
- The number of hospitals will decrease. By 1990, 25 percent will be run by investor-owned corporations. "For physicians, hospital privileges will be just that — 'privileges.'"
- The federal government will increase pressure to cut medical costs.

For some physicians, joining a group practice or organization such as a Preferred Provider Organization (PPO) may be the way to go. However, those physicians wishing to remain in private practice, will have to learn new ways of managing their practices and getting — and keeping — patients. In *Colorado Medicine* this month, we are beginning a series of articles on marketing the private medical practice and also on IPAs/PPOs; what they are and what they will mean to the Colorado physicians.



Private Practice Physician: Sink or Swim

Special Report pp. 12–16

AMA Gives Economic "Swimming Lessons" To Private Practice Physicians

Marketing is communication. Communicating who you are, what your specialty is, when you are available, where you are located and how to contact you. Marketing is a process. An ongoing process of finding out what your patient's needs are and matching your services to those needs.

The basic principles of marketing and the application of them within the confines of medical practice were presented in "Marketing Strategies for the Private Practice," a seminar given by the American Medical Association's Department of Practice Management. Clear Creek Valley Medical Society hosted the event. The following report was written by Frances Fowler of the Advertising and Member Services Department at CMS.

"Marketing Strategies for the Private Practice" was developed to address the concerns of physicians in private practice. These physicians are at a disadvantage these days. They have to compete with the proliferation of alternative health care delivery systems as well as cope with the changes occurring because of cost-cutting initiatives on the part of government, business, labor and the insurance industry. Physicians in private practice share the same concerns for quality medical care on a cost effective basis as their colleagues in group practices. However, the market share of patients seeking private practices is diminishing.

Between 1969 and 1980 the number of medical groups rose from 6,371 to 10,762 — an increase of 69 percent. Physicians practicing in groups rose from 40,093 to 88,290 — an increase of 120 percent. A subtle response to the needs of patients? Perhaps. Collectively a group can often administer to the greater and differing needs of patients. However, AMA's Department of Practice Management does not feel that the private practice has to be at a disadvantage. By evaluating and recognizing the needs of patients seeking his services, the physician can position himself responsively and strategically market to that segment of patients.

Following are a few of the marketing concerns and strategies presented by the AMA.

Referrals: Physicians typically have many "markets" to which they must appeal if they are to remain successful — patients, obviously, but also other physicians, third party payers, community agencies, etc. Specialists who rely on other physicians for the bulk of their patients must market themselves to these other physicians in the same way primary care physicians must market themselves directly to patients.

Pricing: Patient surveys consistently illustrate that dissatisfaction with physician "high" fees is one of the biggest irritations experienced by patients. Several pricing options include competive pricing, cost, value or fixed pricing, high volume, ability to pay and base price + extras pricing. Pricing strategies should be fiscally and environmentally sound, that is, sensitive to both the physician and the patient's needs. Further, clear and concise communication of fee policies is absolutely necessary between the patient and the physician and his staff.

Availability: Convenience is becoming an increasingly significant factor in the choices made by patients. If their physician is unavailable when they want or need

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care, they will look elsewhere. A physician can take advantage of this situation by offering alternative hours in the morning, evening or weekend. Examination of telephone availability for information, scheduling and emergencies is paramount. This is the only mode of communication to patients, present and potential, that represents a physician when he cannot do it personally.

Expansion of Services: Another way of achieving marketing goals is to identify a particular group of patients with specific needs or desires and then design new services or expand existing services that are specifically targeted to this group.

Increase in Visibility: Patients obviously cannot choose a physician if they do not know he exists. Also, it is a real benefit to prospective patients, as well as an essential feature of a practice building program to inform patients of the full range of services available, practice philosophy, and operations policies and procedures.

Patient Relations: The product that is marketed is the service a physician provides. Competent medical care is an absolutely essential feature of this service, but clinical competence alone will not create satisfied patients who are enthusiastic about recommending a physician to others. Patients don't want to be treated by just a competent professional, they also want to be cared for by a warm and caring human being. How staff members treat patients and the attitudes with which their medical needs are addressed are important.

Marketing: A Useful Tool

There remains a (perceived) disadvantage that physicians must overcome if they are to compete successfully: the stigma of marketing. An organization can develop a marketing plan and advertise without the same stigma as would be attached to an individual physician providing the same information. Are not HMOs, PPAs and IPAs just groups of physicians? A single physician has the same right to use the same marketing tools as does a group of physicians.

Further, there appears to be a misconception among many physicians about marketing and advertising. Advertising is not synonymous with marketing; it is not the entirety of marketing. It is one form of communication within the process of marketing. It is not inherently fraudulent or deceptive; it can be accurate and useful. Advertising, as defined by the U.S. Supreme Court, is "commercial speech to inform the public of the availability, nature and prices of products and services, and thus perform an indispensable role in the allocation of resources in a free enterprise system."

Marketing can involve any or all of the aforementioned strategies. Time, resources and need will determine the marketing plan that best suits a physician's goals and philosophies.

The health care industry has long been isolated from the competive environment of the free enterprise system. It now has been thrown into the current and will either sink or swim. AMA is teaching swimming lessons — very well. More information on AMA's "Marketing Strategies for the Private Practice" can be obtained by contacting AMA's Department of Practice Management, 535 Dearborn Street, Chicago, Illinois. Phone (312) 751-6251.

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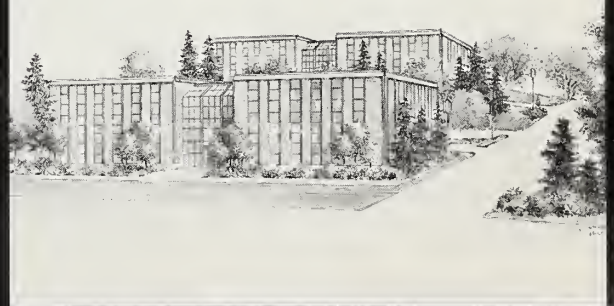
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How Do You Define a PPO?

This article is the first in a two-part series which addresses the issue of PPOs, their common characteristics, their development, and implications for physicians. It was written by David Hlavac, CMS Director of Medical Economics and Professional Relations. Next month's article will report on the specific development of the PPO market within Colorado.

A little more than two years ago Dr. Kenneth Platt, Medical Director of the Colorado Foundation for Medical Care, discussed some of the major issues likely to be facing Colorado physicians. Among the items he identified in his article for *Colorado Medicine* was the development of a new "wrinkle" in the health care delivery system termed Preferred Provider Organizations, or PPOs.

At that time, many physicians were not even aware of what the acronym "PPO" stood for. Now PPOs have begun to proliferate around the country. Colorado physicians, in particular, have seen the growth in organization and development of PPOs, and a number have become participating physicians in one or more.

Since PPOs, unlike HMOs, do not exist as a legal entity, there is no single definition of just what a PPO is. There is wide variation among the PPOs in existence along the lines of organization and contractual arrangements. One source has been quoted to say that, "If you've seen one PPO, you've seen one PPO." There are, however, several features that are common to nearly all PPOs:

- a limited panel of physicians, hospitals, or combination of physicians and hospitals
- a negotiated fee schedule, often at a discounted rate ranging from 5 to 20 percent
- a financial incentive for patient enrollees to utilize participating providers
- some form of utilization review and/or other quality assurance mechancisms
- use of the primary care physician as the "gatekeeper" to the system

The major distinctions between PPOs and HMOs are the minimization of financial risk to the providers, and the maintenance of patient freedom of choice. PPOs enable the provider to continue to practice in a fee-for-service setting, while allowing patients the freedom to choose between receiving service from their usual source of care or from a PPO provider.

The absence of a statutory definition allows most PPOs to develop outside the regulatory arena of most state insurance laws, since the PPO is not an entity per se, but rather an arrangement between an employer and a group of providers.

In practice, PPOs are frequently sponsored by groups of physicians, hospitals, or an insurer. The groups then either market their benefit package directly to employers, or through a third party administrator. The PPOs negotiate providers' fees and other cost reducing features, such as reductions or changes in utilization patterns. There are a number of potential benefits for each party to the arrangement.

PPOs are attractive to employers because of the short-term cost savings associated with discounted fees and the long-term savings that might accrue from improved utilization patterns. Hospitals view PPOs as a

PPO Meeting Held at CMS

A meeting was held on November 22, 1983 at the CMS offices to discuss possible medical society involvement with IPAs and PPOs in Colorado. Meeting participants included CMS physicians, physician representatives from local IPAs, PPOs and HMOs, as well as CMS and component society staff. John A. Whitesel, MD, President of CMS, chaired the meeting.

The following questions were raised at the meeting: What role should CMS play with IPAs and PPOs in Colorado? Should CMS be an advocate for these types of organizations? Should CMS act as an information resource? Should CMS become involved in legislative efforts for IPAs/PPOs? Should the Colorado Foundation for Medical Care become involved with these organizations? Should CMS become a forum for discussion of issues relating to IPAs/PPOs? Should CMS coordinate an information data bank on IPAs/PPOs?

The consensus at the meeting was that CMS should not become a statewide IPA. However, all participants agreed that CMS should become a forum for discussion of pertinent issues, serving as a liaison for such organizations as well as fulfilling the CMS role of physician's advocate.

Participants also agreed that CMS can act as a source of legal advice for groups interested in developing IPAs/PPOs. Additionally, CMS can become a "watchdog on quality," perhaps setting standards for quality of care, utilization and cost containment. In short, attendees at the meeting agreed that CMS' primary role at this time should be to act as a resource of information for groups or individuals who have formed or who are interested in forming IPAs or PPOs.

means of maintaining or enlarging market share, often in the face of declining utilization and occupancy rates. Physicians find PPOs appealing as a means of attracting new patients or maintaining patient loads in the midst of a competitive environment, plus the administrative advantages of rapid turnaround in claims payment and lower administrative overhead with minimum financial risk. Patients benefit from the continued availability of freedom-of-choice in the providers they use, plus a generally expanded benefits package through the PPO option.

California and Colorado are generally acknowledged to be the two states that gave impetus to the start of the PPO movement. Mountain Medical Affiliates and the Sloan's Lake Medical Group were among the earliest of the PPOs in Denver, both having been in operation for approximately three years.

Since that time, the number of PPOs both in Colorado and nationwide have increased significantly. Linda Ellwein of InterStudy, one of the major health policy research organizations monitoring the development of PPOs, cites the difficulty in tracking the number and range of new PPOs entering the market. "There is no nice and neat way to follow their progress," Ellwin notes, "In addition, a head count is tricky. If you have a hospital network PPO composed of 12 hospitals, do you count one PPO for the network, or 12 PPOs, one for each hospital?" In addition, each PPO is shaped by the needs and demands of the local health care market, so there is great flexibility and variety in the forms that a PPO may take.

There are certain conditions that appear to be favorable to the development of PPOs — an oversupply of physicians and hospitals, leading to a highly competitive environment; a strong marketing effort by HMOs; a large number of employers dissatisfied by recent health care cost increases (particularly among self-funded employers and union trust funds); and wide variations in the prices for similar services among competing providers.

While there is evidence of strong interest on the part of employers in the PPO concept, up to now business has been somewhat cautious in actively pursuing the PPO option. It has been predicted, however, that the PPO "movement" will continue to show rapid growth. It represents the "most simple form of entry vehicle to the world of price competitive medical care," according to Dr. Paul Ellwood, head of InterStudy.

PPOs have not been in existence long enough to conclusively demonstrate their effectiveness at reducing costs. The success of PPOs, however, is highly dependent on their ability to attract physicians who already practice cost-conscious medicine, or who are willing to accept the strong utilization controls that are built into most PPOs.

In a case last year (Maricopa Foundation for Medical Care v. the U.S.), the U.S. Supreme Court ruled that establishing maximum fees constituted illegal price-fixing. Since that case there has been some concern about the antitrust issue and how it will affect PPOs. Up to the present, though, the FTC appears to be looking favorably upon the development of PPOs.

Recently, a U.S. Justice Department official was quoted as stating that, "as a general matter, we believe that the emergence of PPOs can benefit providers and hospitals." Unless the design of the PPO obviously violates the antitrust rules, then, there is probably not a great deal of threat from government litigation over price-fixing or restraint of trade.

Although PPO development has proceeded so far without the same kinds of regulations which have affected HMOs, the possibility exists that that may change. Ron Wyden, a congressman from Oregon, has recently introduced federal legislation that would override any state insurance laws which hinder the development of PPOs.

Physicians have begin to show a great deal of interest in PPOs. Despite fears by some that the competitive thrust of PPOs and emphasis on cost control will negatively affect quality of care and spell the end of traditional medical practice, most physicians see PPOs as an acceptable alternative to greater government regulation, or such other alternative delivery systems as HMOs. PPOs offer doctors the means to actively market their medical practices, while still retaining the fee-for-service and patient freedom-of-choice features that characterize the private practice of medicine.

As pressure from business and government continues to mount to stem the rise in health care costs, initiative on the part of physicians becomes more important. R. Karl Alfred, Chief of Medicine at St. Vincent Hospital, Cleveland, stated in a recent Wall Street Journal article, "Every one of us now realizes that we have only a few years to prove that the medical profession itself can do something about rising costs before the government takes the decision-making out of our hands."

Ed. note: Next month's article will discuss the growth of PPOs in Colorado, specifically in the Denver metropolitan area, and detail the reaction of Colorado physicians to the movement.

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Dr. Portia

James J. Delaney, MD, Historian, Colorado Medical Society

If I were to ask almost anyone today if anything good came of the Russian Revolution in 1917, I'm sure the answer would be no. And yet one of eastern Colorado's best known and beloved physicians would never have settled here except for that revolution. Actually she came close to ending her career in 1917. The story of her life and contributions to those who came to her for care reads like a best selling novel.

Dr. Portia, as she was known to all her friends and patients, was born in Paxville, South Carolina, August 6, 1887. She pursued a career as a schoolteacher, an honorable profession for a woman in those days, but longed to be a physician. She met her future husband, Alexis Lubchenco, a Russian agronomist, by chance. He had been sent to America in 1907 by the czar to study cotton production. Portia's family befriended and housed him during his sojourns in this country. Their friendship gradually deepened and he encouraged her to pursue a medical education. There were many women physicians in Russia, including his sister.

The idea of a southern gentlewoman becoming a physician was not very popular at the time. She was refused admisson to medical school in South Carolina but persuaded the faculty of the Medical College of North Carolina to admit her. She became the first woman graduate of the school in 1912, graduating number two in her class. She was accepted for an internship in Boston but declined the position to marry Alexis. Prior to her graduation from medical school he had been scheduled to sail on the Titanic, but missed its ill-fated voyage because of a travel conflict in Russia. He still managed to be present for her graduation. They were married soon afterward and moved to Russia where she became a school physician and began to raise their family while he continued his experiments in cotton growing.

The story of how their pleasant, prosperous life quickly disintegrated after the czar was removed from power is chronicled in her biography, *Doctor Portia,* written by her longtime friend, newspaper woman Anna C. Petteys, of Sterling, Colorado. The terror they faced as anarchy replaced every vestige of law and order is frightening to imagine. The story of their flight to freedom eastward to Japan almost defies belief. Once out of Russia, the family still faced almost insurmountable obstacles of contagious illness and unsympathetic immigration officials in attempting to return to America.

The book was first published in 1964 by Golden Bell Press and widely distributed throughout Colorado. It became must reading for women medical school each year. During Colorado and, until recently, a copy of the book was given to the outstanding woman graduate of the Medical School each year. During the last 20 years the book has gradually been withdrawn from circulation and only a relatively few copies remain available, mostly in private libraries. Fortunately, however, the families of both the author and Dr. Portia have financed and authorized a second printing of the book. I would urge you to consider buying a copy for your own personal library. Not only is the book well written and easy to read, it is entertaining and an excellent bit of history. The book can be ordered from the Denver Medical Library by calling 839-6670. Proceeds of the books will be used to support the library.

After returning to South Carolina, Dr. Portia set up a private general practice while her husband began raising cotton on their farm, which they had purchased shortly after their marriage. Hard times and the boll-weevil prompted them to move to Haxtun, Colorado in 1931 where she joined her brother, Jim McKnight, in practice.

Within two years economic disaster visited their community forcing them to move again. This time it was the drought which caused dust storms. However, this time they moved only a short distance, to Sterling. Sugar beets and irrigation from the Platte River saved Sterling from the fate of the dry land farmers.

When Dr. Portia first moved to Sterling, there were two hospitals. A new Logan County hospital was built in the late 30's to unify the community's medical service. She was elected the first chief of staff by her fellow physicians. She carried on a general family practice but also developed expertise in anesthesia and became the primary anesthetist in the community as well. After 35 years of practice in northeastern Colorado, Dr. Portia decided to retire in 1966.

She moved to Denver to be near her family but was soon back at the practice of medicine. At first she saw patients in her apartment and later she worked with The Denver Clinic and the Medical Care and Research Foundation. She primarily cared for nursing home patients, becoming their friend and companion as well as their physician.

Dr. Portia retired again in January, 1972. She died quietly November 28, 1978 at the age of 91. She is still revered by those who knew her and still continues to be honored. She was named Colorado Mother of the Year in 1954. Her most recent honor was the posthumous award of the John and Joe LeConte Medallion given by the South Carolina Hall of Science and Technology.

She was preceded to the grave by her faithful, loving and inspirational husband in 1940. He was sixteen years her senior. He had supported

her in all she did, encouraged their children to seek excellence in their school and life time pursuits. He provided laboratory services at the hospital where his wife worked and tried to join her in the practice of medicine. However, he could find no medical school to admit a man over fifty.

The senior Lubchencos have left a legacy of five children and twenty-one grandchildren. Three of their children followed their mother's footsteps into the practice of medicine. Two also married physicians, and three of their grandchildren are practicing medicine.

Their oldest child, Alexis (Luby), was born in Russia. He did his undergraduate work at Clemson and received his MD Degree from CU. After service in the 29th General Hospital in World War II, he studied pathology and became one of the pathologists at Denver Presbyterian Hospital. His service to the community and especially to the Colorado Chapter of the American Cancer Society, is well known. He died of a heart attack in the fall of 1982.

Lula (Dr. Lu), the second child, also born in Russia, took her undergraduate work at DU and received her MD degree from CU in 1939.

Dr. Lu married Dr. C. J. Josephson, a noted Denver cardiologist. She took a one year rotating internship at CU followed by a year's pediatric training at Rochester, New York. She completed a pediatric residency at Denver Children's Hospital in 1944. She did basic research on cystic fibrosis in 1945 and 1946. In 1947 she went to Boston for a year for her husband's fellowship with Paul Dudley White. When she returned to Denver, she was at somewhat of a loss as to what she would do.

She talked to Harry Gordon who was then Chairman of Pediatrics at CU. The long standing research project to study premature babies was just starting under the direction of Drs. E. S. Taylor and Gordon. There was a half-time pediatric salary when she accepted. With only a couple of minor exceptions, she continued in that position until her "retirement" in 1978. As anyone connected with obstetrics and pediatrics knows, she has become one of the premiere neonatologists in the world. Dr. Lu's work relating gestational age and birth weight to neonatal survival has become the standard of the world.

Two of her four children are physicians. Patricia practices pathology in Albequerque, New Mexico, and Johanna practices obstetrics and gynecology in Cedar Rapids, Iowa. Dr. Lu has recently returned from Milan, Italy where she addressed the neonatology division of the University of Milan on the subject of "Living With a Down's Syndrome Child." In spite of a career in academic medicine in which she has lectured extensively on many subjects, this was the first time she could muster the courage to talk on the subject of Down's Syndrome. Her daughter, Gretchen, accompanied her on the trip and served as an inspiration to the audience.

The third Lubchenco child, also born in Russia, is named after her mother. Portia followed her mother's footsteps into teaching but stopped short of medical school. She married a Sterling businessman, Kenneth Curlee. One of her four sons is a family physician, practicing in Grand Junction. After the death of her husband, she married Francis Whittaker, a blacksmith and artist and now lives in Aspen.

The fourth child, Michael, also followed in his mother's footsteps. He did his undergraduate work at the University of South Carolina and Denver University. He received his MD from CU. After two years of military service spent at the VA Hospital in Southeastern Colorado, he returned to Denver to take a surgical residency. He met his wife, LeMeta Dahl, when she was an intern at Children's Hospital. His sister was working there at the time, but she had nothing to do with their introduction or courtship.

Mike maintained a surgical office in Denver and served as the main surgical consultant in Sterling until 1962 when he developed chest pain and decided to slow down a bit. He had commuted between Denver and Sterling every week for many years. He worked in the emergency room at Denver General Hospital for years right after its last break with the medical school. He then became the full time Director of Medical Education at the Presbyterian Hospital. He retired in 1981, disabled by rheumatoid arthritis. His wife served the public sector well, staffing most of the city's well-baby clinics until 1980 when she retired.

None of their six girls has chosen medicine as a profession. This family is reknowned for their extensive collection of nativity sets from many nations and cultures throughout the world. Their collection cuirrently numbers about 250 sets. Some of their collection was on display last Christmas (1982) at the Arvada Center for the Arts and Humanities. The collection is truly magnificent.

The fifth child, Peter, strayed from education and medicine to become an engineer. He graduated from the University of Denver. He died of an apparent heart attack at the age of 48, in 1971.

The Lubchenco medical torch has now been passed to the third generation. They have a grand tradition to uphold.

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Drug Therapy Questions and Answers

This monthly column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column are generated from calls received by the Rocky Mountain Drug Consultation Center from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The center is available from 8:00 AM to 5:00 PM Monday through Friday, with 24 hour on-call-service.

The director of the center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center. Medical Director is Earl W. Sutherland, MD, Ph.D, Assistant Professor of Medicine, UCHSC. The article on alternative therapy for inflammatory bowel disease was written by Larry K. Golightly, Pharm.D. The article on the use of cimetidine to heal peptic ulcers induced by non-steroidal anti-inflammatory agents was written by Susan C. Smolinske, B.S., R.Ph.

Sulfasalazine Hypersensitivity — Alternative Therapy for Inflammatory Bowel Disease

Request:

A patient with ulcerative proctitis developed a relatively severe hypersensitivity reaction to sulfasalzine. What other agents may be used?

Response:

Adrenal *corticosteroids* remain the most immediately effective drugs for treating inflammatory bowel disease.[1,2] Effects may not be long-lasting and steroids carry the potential for numerous side effects. Steroid retention enemas or hydrocortisone in an aqueous or foam base are particularly beneficial in ulcerative proctitis.[3] Corticosteroids are of no benefit in maintaining remission.[4]

Investigations in Britain several years ago reported that oral *cromolyn* provided symptomatic improvement in some patients with ulcerative proctitis.[5] More recent trials with larger numbers of patients have failed, however, to confirm beneficial effects on symptomatology relapse rate, or indicators of colonic inflammation.[6,7,8] A modest effect may be seen in preventing relapses in patients who are unable to tolerate sulfasalazine.[9] Use of cromolyn for this purpose in the United States is presently impractical since 800–2000 mg per day is required as a therapeutic dose; the available 20 mg capsules would be very difficult and very expensive to use. A higher strength formulation is investigational.

Metronidazole has been demonstrated to prevent irritant-induced ulcerative colitis in animals.[10] Alterations in anaerobic bowel flora occur which correlate with improvement in symptoms of patients with inflammatory bowel disease.[11] In an open trial of 21 patients with perinial Crohn's disease, 20 mg/kg/day of oral metronidazole afforded a decrease in drainage, erythema, and induration in all patients, complete healing of lesions in 10 patients, and partial healing in 5 others.[12] Similarly, a national multicenter randomized trial in Sweden[13] found responses with 800 mg metronidazole per day which were considered equivalent to that attained with sulfasalazine in degree of symptomatic and laboratory indices of disease activity in 78 patients with Crohn's disease. Metronidazole was effective upon crossover in many patients who failed to respond to an initial course of sulfasalazine. To our knowledge, no data on the use of metronidazole in ulcerative colitis or proctitis are yet available, although clinical trials are currently in progress.

Sulfasalazine remains the preferred agent for long-term maintenance of remission in patients with ulcerative colitis.[1,2,4] Many patients who have experienced a rash or fever after taking sulfasalazine may be desensitized. In one series, seven of eight adults experiencing such reactions were able to resume therapeutic dosages (2 g per day) following desensitization using extemporaneously prepared oral formulations of sulfasalazine.[14] Capsules were prepared containing 1 mg, 10 mg, and 100 mg. All patients started with 1 mg daily and the dose was progressively doubled; pauses in this dosage increase occurred when 10 mg and 100 mg daily were achieved, each of these doses being taken for one week before doubling again. The rate of dosage increase varied, but 100 mg was never reached before 14 days and the normal 500 mg tablet strength was never reach-

ed before 23 days. Patients were instructed that if any reaction such as fever or skin eruption developed, the dose should not be increased further but should be continued until the reaction "settled down."

Conclusion:

Corticisteroids are the most effective agents available for acute exacerbations of ulcerative proctitis. In patients who cannot take sulfasalazine, oral metronidazole may be beneficial, although reliable data for the use of this agent are presently available only for patients with Crohn's disease. Sulfasalazine desensitization may be considered for patents experiencing fever and/or rash with this agent.

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Cimeridine — Treatment of Anti-inflamatory Drug-induced Ulcers

Response:

The use of cimetidine to heal peptic ulcers induced by non-steroidal anti-inflammatory agents (NSAID) has been evaluated in several controlled and uncontrolled studies. In an endoscopically controlled study of patients with peptic ulcer and continued anti-inflammatory therapy (excluding aspirin), 43 percent were healed at four weeks following cimetidine 1200 mg/day compared to 50 percent healed following placebo.[1] In an uncontrolled study, Croker et at[2] treated 21 patients with NSAID-induced ulcer with cimetidine. Seventeen of the 21 healed within three months, and 11 of the 17 continued to take full doses of their anti-inflammatory drug.

In a recent well-designed prospective study,[3] 18 patients with aspirin-induced ulcer and rheumatic disorders were randomized to receive either cimetidine 300 mg qid plus Maalox® 30 ml prn or antacid plus placebo, while continuing on the same dose of aspirin. On the endoscopic evaluation at 2 months, 56 percent of cimetidine-treated ulcers and 44 percent of placebo-treated ulcers were healed. The healing rate correlated with the ulcer size; only 20 percent of ulcers larger than 1 cm in diameter healed. Larger ulcers were extremely resistant to either therapy, taking six–26 months to heal. Ulcers less than 0.5 cm in diameter had average healing rates of 90 percent, regardless of the treatment. Cimetidine was statistically superior to antacids alone in relieving symptoms of epigastric pain, and the average daily dose of antacid was twice as high in the placebo group. This higher antacid intake may explain the lack of difference in healing rates. Improvement in the number of gastric erosions and erythema was similar in both treatment groups. Finally, the ulcer recurrence rate after 22 months of cimetidine or antacid maintenance therapy was 1/11; eight of 11 were treated with cimetidine. However, all patients were switched to enteric-coated aspirin.[3]

Not all investigators are convinced that cimetidine will completely resolve all manifestations of NSAID-induced ulcer. In patients with idiopathic peptic ulcer disease, cimetidine does not protect against perforated ulcer. In a 15 year study of patients with perforations, 12.5 percent were receiving cimetidine at the time of perforation.[4] Two patients are reported to have experienced rapid dyspeptic relief from cimetidine therapy (600 mg HS) while continuing on their anti-inflammatory regimen, but subsequently developed duodenal perforation.[5]

Conclusion:

Cimetidine has not been demonstrated to be significantly superior to antacid therapy in the treatment of NSAID-induced ulcer, but may provide rapid relief of pain. Large ulcers are particularly resistant to treatment and may require 6 months or longer to heal if NSAID therapy is continued. Due to reports of ulcer perforation during cimetidine treatment, patients should be followed closely, with frequent endoscopic evaluations.

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January, 1984

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26-30 **Basic Medical Radiation Physics** — Registry Hotel, Dallas Texas. Fee: $500.00. 50 hours AMA Catrgory 1 credit and licensing requirements. Contact the National Institutes for Professional Education, 4880 River Bend Rd., Boulder, Colorado 80301. Phone: (303) 449-4621 or (800) 421-8452.

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2 **Neuropsychiatric Grand Rounds** — Colorado State Hospital, Pueblo, Colorado. 1:00–3:00 pm. APA approved for Category 1 credit. Contact James H. Scully, MD, Colorado State Hospital, 1600 West 24th St., Pueblo, Colorado. Phone: (303) 543-1170.

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Book Corner

(Continued from p. 9)

capitalization." That takes some understanding. We last examples of independent capitalism have had enormous support from government and foundations to underwrite the research that provides the technical knowledge we use. That scientific knowledge is our capital just as land is the farmer's. Insurance programs and governmental funds have allowed our hospitals to equip themselves with expensive staff and machinery from which we earn our livings. Imagine the situation if a cardiologist just out of his fellowship had to find the funds to equip and staff a catheterization laboratory before he could do any of those lucrative procedures that Adam Smith never even thought of.

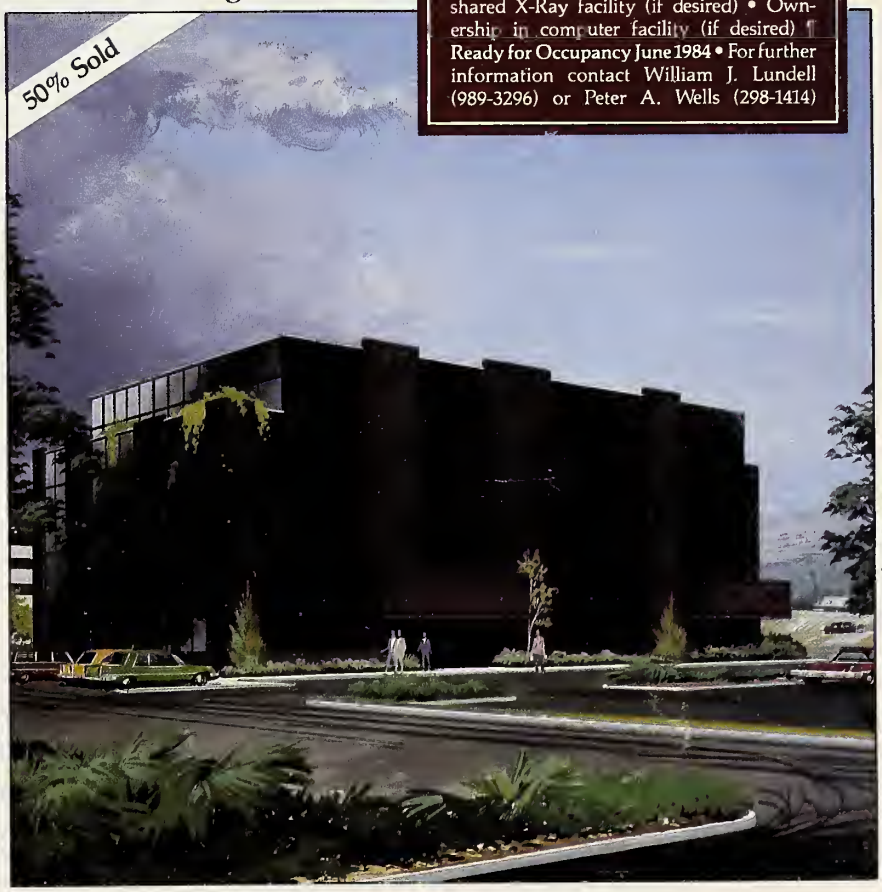
What is to come? Starr has predictions that are hard to deny after reading his careful history of the events that have transpired. He believes that physicians are entering a zero sum game and that we will experience bitter competition from our colleagues, from healers outside the regular doctor ranks, from hospitals, and from sources we have not dealt with much in the past, large corporations. He sees medicine undergoing a corporate transformation that will lead to control of medical operations being located farther and farther from the actual site for those operations, more horizontal integration (corporations owning hospitals in many locales) and more vertical integration (corporations owning and operating health facilities that include outpatient care, hospitals, nursing homes, and in fact, any sort of medical or health activity that might turn a profit.) He foresees more diversification of "medical" operation but more concentrated ownership and control, and far less power for physicians whatever their practice structure. Of course, these changes are already upon us. In 1959, when I entered medical school, there were 141 doctors for every 100,000 people in the United States. Today the ration is about 190 per 100,000 and by year 2000 that number will reach 240. In 1980 30 percent of the 988,000 community hospital beds in this country were in multi-institutional corporations. The fastest growing industry in the country is not micro-computers but for-profit hospital corporations.

Some of my friends have bought Starr's book to read its last 100 pages, devoted to his predictions for the future. That is, I think, a mistake. Paul Starr can not see into the future. Any number of unexpected events may occur to alter our route. For example, although Starr's history is remarkably current, even including actions of the Reagan administration, he did not know about the latest transformation of American medicine, diagnostic related groupings. Who knows what else is in stock for us? The power of this book lies in its first three-quarters, the carefully detailed history of American medicine. Starr's understanding of the growth of our professional sovereignity is remarkable. Understanding our own history may help us avoid the need to repeat it. We might even avoid some of the solopsism that leads to arrogance and impotence, both heavy weights to carry into the future.

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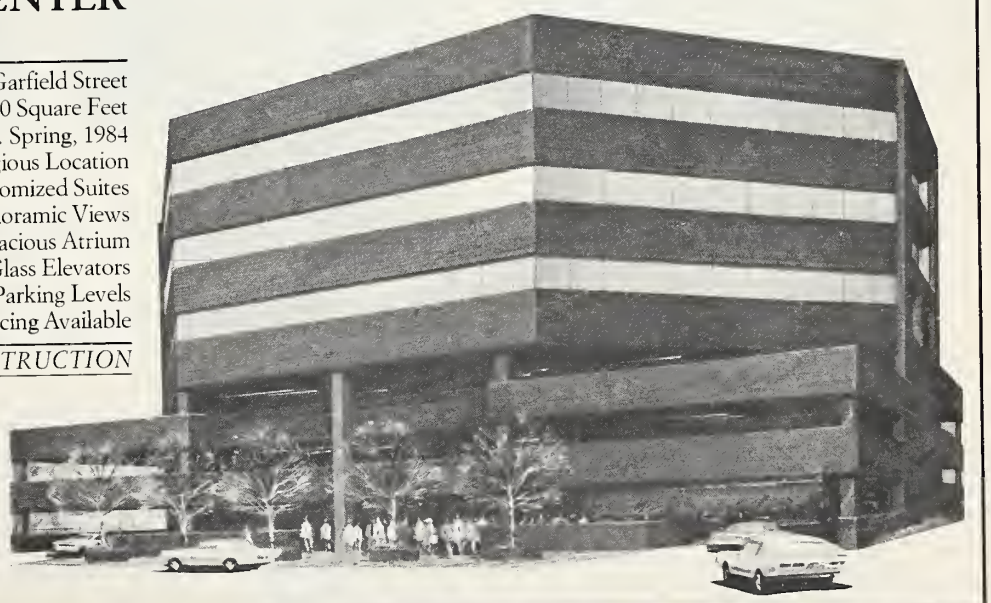
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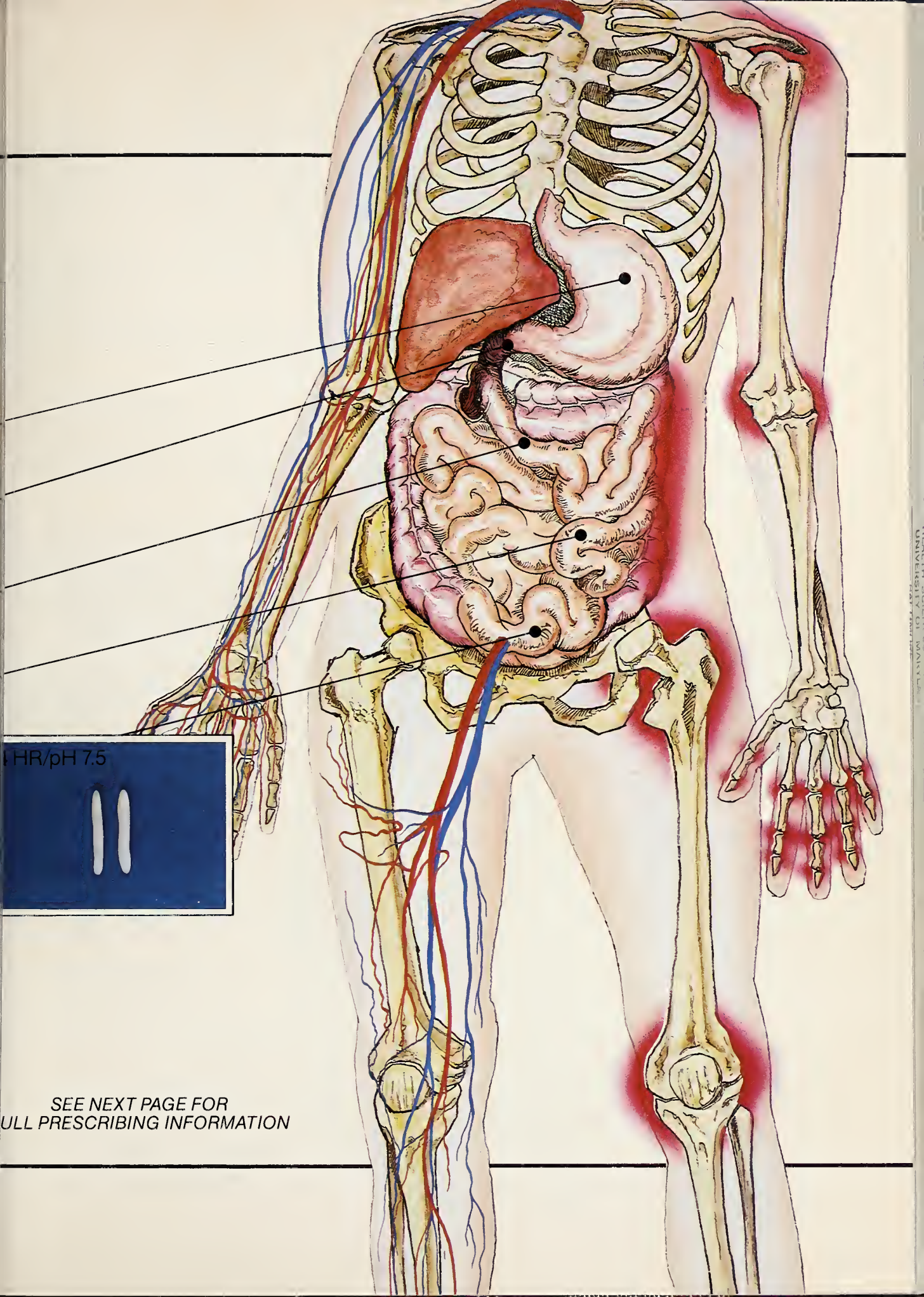


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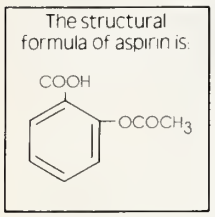
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ZORprin (ASPIRIN) Zero-Order Release

DESCRIPTION: Each capsule-shaped tablet of Zorprin contains 800 mg of aspirin, formulated in a special matrix to control the release of aspirin after ingestion. The controlled availability of aspirin provided by Zorprin approximates zero-order release; the *in vitro* release of aspirin from the tablet matrix is linear and independent of the concentration of the drug. □ **CLINICAL PHARMACOLOGY:** Aspirin, as contained in Zorprin, is a salicylate that has demonstrated anti-inflammatory and analgesic activity. Its mode of action as an anti-inflammatory and analgesic agent may be due to the inhibition of synthesis of prostaglandins, although its exact mode of action is not known. □ Zorprin dissolution is pH-dependent. *In vitro* studies have shown very little aspirin to be released in acidic solutions; whereas, Zorprin releases the majority of its aspirin (90%) in a zero-order mode at a neutral to alkaline pH. It is this pH dependence of Zorprin that reduces direct contact between aspirin and the gastric mucosa, resulting in a reduction of its gastrointestinal side-effect potential. □ Bioavailability data for Zorprin have confirmed that plasma levels of salicylic acid and acetylsalicylic acid can be measured 24 hours after a single oral dose. This substantiates a twice daily dose regimen. Multiple dose bioavailability studies showed similar steady-state salicylate levels for Zorprin as for conventional release aspirin using the same total daily dose. Long-term monitoring of salicylate levels showed no signs of accumulation once steady-state levels were reached (4-6 days). □ Studies of *in vivo* prostaglandin levels (PGE2) have shown Zorprin plasma levels of salicylic acid and acetylsalicylic acid to reduce PGE2 levels 14 hours after a single oral 800 mg dose while an equivalent dose of aspirin produced a reduction of PGE2 levels only through six hours. Zorprin's effect on prostaglandins other than PGE2 has not been determined. □ Salicylates are excreted mainly by the kidney, and from studies in humans it appears that salicylate is excreted in the urine as free salicylic acid (10%); salicyluric acid (75%) salicylic phenolic (10%); acyl glucuronides (5%) and gentisic acid (<1%). □ **INDICATIONS & USAGE:** Zorprin is indicated for the treatment of rheumatoid arthritis and osteoarthritis. The safety and efficacy of Zorprin have not been established in those rheumatoid arthritic patients who are designated by the American Rheumatism Association as Functional Class IV (incapacitated, largely or wholly bedridden, or confined to wheelchair, little or no self-care). □ In patients treated with Zorprin for rheumatoid arthritis and osteoarthritis, the anti-inflammatory action of Zorprin has been shown by reduction in pain, morning stiffness and disease activity as assessed by both the investigators and patients. □ In clinical studies in patients with rheumatoid arthritis and osteoarthritis, Zorprin has been shown to be comparable to conventional release aspirin in controlling the aforementioned signs and symptoms of disease activity and to be associated with a statistically significant reduction in the milder gastrointestinal side effects (see ADVERSE REACTIONS). Zorprin may be well tolerated in some patients who have had gastrointestinal side effects with conventional release aspirin, but these patients when treated with Zorprin should be carefully followed for signs and symptoms of gastrointestinal bleeding and ulceration. □ Since there have been no controlled trials to demonstrate whether or not there is any beneficial effect or harmful interaction with the use of Zorprin in conjunction with other nonsteroidal anti-inflammatory agents (NSAI), the combination cannot be recommended (see **Drug Interactions**). □ **Because of its relatively long onset of action, Zorprin is not recommended for antipyresis or for short-term analgesia.** □ **CONTRAINDICATIONS:** Zorprin should not be used in patients known to be hypersensitive to salicylates or in individuals with the syndrome of nasal polyps, angioedema, bronchospastic reactivity to aspirin, renal or hepatic insufficiency, hypoprothrombinemia or other bleeding disorders. Zorprin is not recommended for children under 12 years of age; it is contraindicated in all children with fever accompanied by dehydration. □ **WARNINGS:** Zorprin should be used with caution when anticoagulants are prescribed concurrently, since aspirin may depress platelet aggregation and increase bleeding time. Large doses of salicylates may have hypoglycemic action and enhance the effect of the oral hypoglycemics, concomitant use therefore is not recommended. However, if such use is necessary, dosage of the hypoglycemic agent must be reduced. The hypoglycemic action of the salicylates may also necessitate adjustment of the insulin requirements of diabetics. □ While salicylates in large doses have a uricosuric effect, smaller amounts may reduce water excretion and increase serum uric acid. □ USE IN PREGNANCY: Aspirin can harm the fetus when administered to pregnant women. Aspirin interferes with maternal and infant hemostasis and may lengthen the duration of pregnancy and parturition. Aspirin has produced teratogenic effects and increases the incidence of stillbirths and neonatal deaths in animals. □ If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus. □ Aspirin should not be taken during the last 3 months of pregnancy. □ **PRECAUTIONS:** Appropriate precautions should be taken in prescribing Zorprin for patients who are known to be sensitive to aspirin or salicylates. Particular care should be used when prescribing this medication for patients with erosive gastritis, peptic ulcer, mild diabetes or gout. As with all salicylate drugs, caution should be exercised in prescribing Zorprin for those patients with bleeding tendencies or those on anticoagulants. □ In order to avoid exacerbation of disease or adrenal insufficiency, patients who have been on prolonged corticosteroid therapy should have their therapy tapered slowly rather than discontinued abruptly when Zorprin is made a part of the treatment program. □ Patients receiving large doses of aspirin and/or prolonged therapy may develop mild salicylate intoxication (salicylism) that may be reversed by dosage reduction. □ Salicylates can produce changes in thyroid function tests. □ Salicylates should be used with caution in patients with severe hepatic damage, preexisting hypoprothrombinemia, Vitamin K deficiency and in those undergoing surgery. □ Since aspirin release from Zorprin is pH dependent, it may change in those conditions where the gastric pH has been increased as a result of antacids, gastric secretion inhibitors or surgical procedures. □ **Drug Interactions:** (See **WARNINGS**) Aspirin may intertere with some anticoagulant and antidiabetic drugs. Drugs which lower serum uric acid by increasing uric acid excretion (uricosurics) may be antagonized by the concomitant use of aspirin, particularly in doses less than 2.0 grams/day. Nonsteroidal anti-inflammatory drugs may be competitively displaced from their albumin binding sites by aspirin. This effect may negate the clinical efficacy of both drugs. Also, the gastrointestinal inflammatory potential of nonsteroidal anti-inflammatory drugs may be potentiated by aspirin. The combination of alcohol and aspirin may increase the risk of gastrointestinal bleeding. □ Aspirin may enhance the activity of methotrexate and increase its toxicity. □ Sodium excretion produced by spironolactone may be decreased in the presence of salicylates. Concomitant administration of other anti-inflammatory drugs may increase the risk of gastrointestinal ulceration. Urinary alkalinizers decrease aspirin's effectiveness by increasing the rate of salicylate renal excretion. Phenobarbital decreases aspirin's effectiveness by enzyme induction. □ **Pregnancy Category D.** See **WARNINGS** Section. □ **Nursing Mothers:** Salicylates have been detected in the breast milk of nursing mothers. Because of the potential for serious adverse reactions from aspirin in nursing infants, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the benefit of the drug to the mother. □ **ADVERSE REACTIONS: Hematologic:** Aspirin interferes with hemostasis. Patients with a history of blood coagulation defects or receiving anticoagulant drugs or with severe anemia should avoid Zorprin. Aspirin used chronically may cause a persistent iron deficiency anemia. □ **Gastrointestinal:** Aspirin may potentiate peptic ulcer, and cause stomach distress or heartburn. Aspirin can cause an increase in occult bleeding and in some patients massive gastrointestinal bleeding. However, the greatest release of active drug from Zorprin is designed to occur in the small intestine over a period of time. This has resulted in fewer symptomatic gastrointestinal side effects. □ **Allergic:** Allergic and anaphylactic reactions have been noted when hypersensitive individuals have taken aspirin. Fatal anaphylactic shock, while not common, has been reported. □ **Respiratory:** Aspirin intolerance, manifested by exacerbations of bronchospasm and rhinitis, may occur in patients with a history of nasal polyps, asthma, or rhinitis. The mechanism of this intolerance is unknown but may be the result of aspirin-induced shunting of prostaglandin synthesis to the lipoxygenase pathway and the liberation of leukotrienes, e.g. slow-reacting substance of anaphylaxis. □ **Dermatologic:** Hives, rashes, and angioedema may occur, especially in patients suffering from chronic urticaria. □ **Central Nervous System:** Taken in overdoses, aspirin provides stimulation which may be manifested by tinnitus. Following initial stimulation, depression of the central nervous system may be noted. □ **Renal:** Aspirin rarely may aggravate chronic kidney disease. □ **Hepatic:** High doses of aspirin have been reported to produce reversible hepatic dysfunction. □ **OVERDOSAGE:** Overdosage, if it occurs, would produce the usual symptoms of salicylism: tinnitus, vertigo, headache, confusion, drowsines, sweating, hyperventilation, vomiting or diarrhea. Plasma salicylate levels in adults may range from 50 to 80 mg/dl in the mildly intoxicated patient to 110 to 160* mg/dl in the severely intoxicated patient. An arterial blood pH of 7.1 may indicate serious poisoning. The clearance of salicylates in children is much slower than adults and should receive due consideration when aspirin overdosages occur in infants; salicylate half-lives of 30 hours have been reported in infants 4-8 months old. Treatment for mild intoxication should include emptying the stomach with an emitic, or gastric lavage with 5% sodium bicarbonate. Individuals suffering from severe intoxication should, in addition, have forced diuresis by intravenous infusions of sodium bicarbonate and dextrose or sodium lactate. In extreme cases, hemodialysis or peritoneal dialysis may be required. □ (*A plasma salicylate level of 160 mg/dl in an adult is usually considered lethal.) □ **DOSAGE & ADMINISTRATION:** *In order to achieve a zero-order release, the tablets of Zorprin should be swallowed intact. □ Breaking the tablets or disrupting the structure will alter the release profile of the drug. □ It is recommended that Zorprin be taken with sufficient quantities of fluids (8 oz. or more).* □ **Adult Dosage:** For mild to moderate pain associated with rheumatoid arthritis and osteoarthritis, the recommended initial dose of Zorprin is 1600 mg (2-800 mg tablets) twice a day. Because of Zorprin's prolonged release of aspirin into the bloodstream, Zorprin tablets may be taken as a b.i.d. dose. Further adjustment of the dosage should be determined by the physician, based upon the patient's response and needs. Since it will take 4-6 days to reach steady-state levels of salicylic acid with Zorprin, it is recommended dosages be given for at least one week before further adjustment. In general, patients with rheumatoid arthritis seem to require higher doses of Zorprin than do patients with osteoarthritis. □ **Zorprin is not recommended for children below the age of 12.** □ **HOW SUPPLIED: Zorprin Tablets 800 mg;** plain, white capsule-shaped tablets. □ Bottles of 100 Tablets—NDC 0524-0057-01. □ **Caution:** Federal law prohibits dispensing without prescription. □ U.S. Patent No. 4,308,251. □ **Manufactured and Distributed by: BOOTS PHARMACEUTICALS, INC., Shreveport, Louisiana 71106 U.S.A.** 12/8/83 0057-04



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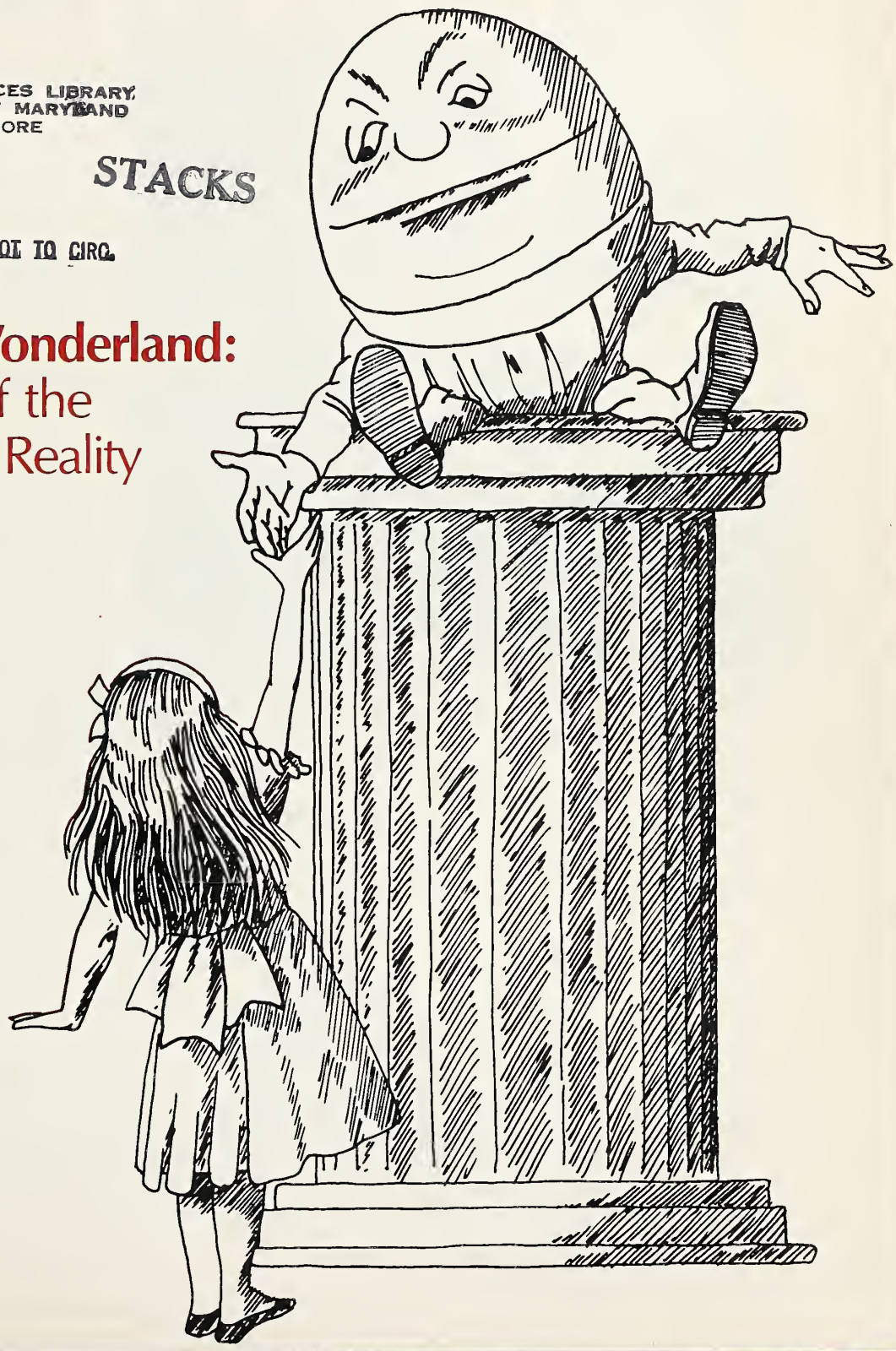
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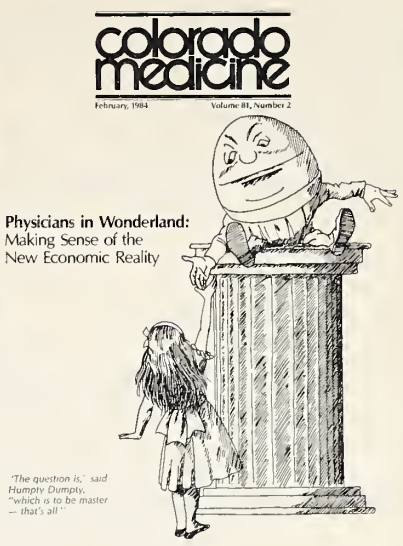
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This Month's Cover

As Humpty Dumpty said, "which is to be master?" Who will control medicine and medical practice in the future, the physician or the marketplace? Is the private fee-for-service physician out of date? Should he or she consider joining one of the alternative health care delivery systems now in place, and if so, which one? This article, "Physicians in Wonderland: Making Sense of the New Economic Reality," is the second in a two-part series which discusses some of the major questions facing the private physician today, in particular the development of PPOs and IPAs in Colorado. The article begins on page 43.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

Political Aspects of Medical Practice

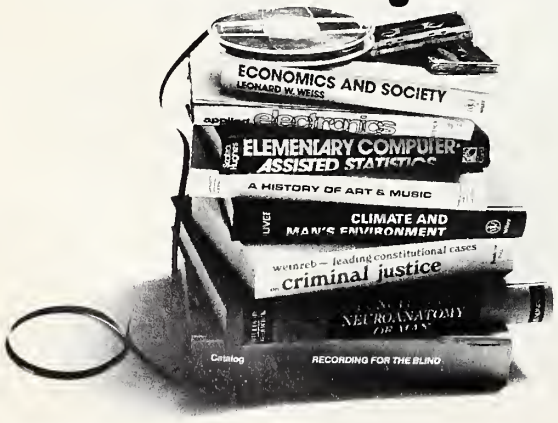
Politics is the art or science of government, of guiding or influencing government policy or of winning and holding control over a government. Politics can mean many things to different people at different times. To medicine, it now means that politics is producing changes in the basic structure of the health care delivery system which will affect our patients and our lives.

The golden age of medicine, in which we could concentrate on sharpening our medical acumen and ignore the political aspects of medical practice, is over. TEFRA, DRGs, proposals for fee freezes and mandated Medicare assignments are just a few of the political issues with which we must be familiar, with which we must work or seek to change.

"Eternal vigilance is the price of liberty" has been attributed to Thomas Jefferson. Elmer Davis said it a little differently: "With great price our ancestors obtained this freedom . . . we were born free . . . but that freedom can be retained only by the eternal vigilance which has always been its price." In 1984, we must couple "eternal vigilance" with "positive action." We cannot afford to be complacent and leave medical politices to the few who have a political leaning. We all must become involved to a greater and greater degree. "What can I do?," you may ask. "I am just one person." We must continue to work together in the medical/political arena, and we must work harder as well as involve more people in the political process.

We must become active by writing letters to state and national legislators (letters do influence legislative decisions), contributing to political campaigns (both monetarily and with time and energy). Non-physician health care provider groups have learned that even though their credentials for the medical privileges they are seeking are suspect, the political trail will lead them to success. And they are succeeding!

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I would, therefore, strongly recommend that you make a resolution to commit yourself to additional political action, making it a part of your daily routine, e.g. by keeping up with issues, writing letters, making year-round contact with legislators and offering to help the legislators of your choice. Join AMPAC and COMPAC and help direct their efforts. These organizations are working for you, but need your help.

A definite method of involvement is to commit yourself to "Participation–'84," a partnership of the different political organizations attempting to coordinate efforts and thus become more effective. Organized by Drs. Robert Yakely and H.R. Safford, "Participation–'84" has as its goals:

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2. Political party involvement, beginning with caucases.

3. Personal involvement in a campaign.

4. Turning out the vote.

An organizational meeting was held December 15, 1983. The discussion included plans for an information/idea exchange and development of a data base. You are invited to join this cooperative effort and may do so by calling the CMS Division of Government Affairs for the next meeting date.

1984 is a presidential election year. Many national and state legislators will be up for re-election or running for a new office. As politics becomes a greater and greater force in shaping the future of health care delivery in this country, we must become more and more involved in the political process. The time to influence that process in November is now. The first step is to make the commitment. The second step is to work with the party of your choice and to join "Participation '84." Only by making this effort today can we be proud tomorrow of the health care delivery system we leave to future generations.

guest editorial

Denis R. Elo, MD, FACS

Seat Belt Legislation — A Must

Few car accident victims were wearing seat belts

Over the past ten years I have had the opportunity to care for many patients who were seriously injured in auto accidents. I am sure that many other surgeons and physicians across this state have shared a similar experience. What bothers me most about this situation is that very few of these patients were wearing seat belts at the time of their accidents. I am sure that many deaths and injuries could have been prevented if these victims had just taken a few seconds to fasten their seat belts.

Motor vehicle crash injuries produce more new cases of quadriplegia and paraplegia than all other causes combined. They also play a big part in the increased incidence of epilepsy and brain damage, and are the single leading cause of facial lacerations and fractures. In Colorado in 1982, 667 people were killed in auto accidents and 97 percent of these people were not wearing seat belts.

Statistics on seat belt usage across the United States show that between 10 and 15 percent of the population actually use seat belts on a regular basis. Some states, such as Michigan, have tried massive media blitzes to educated people in seat belt usage, but have met with little or no success.

Many countries already have seat belt laws

The United States is one of the few industrial countries that does not have safety belt usage laws. More than 30 other countries already have such laws, some dating back to the early 1970s. These countries now have seat belt usage rates of between 75 and 90 percent, instead of 10 to 15 percent, and have noted a marked drop in deaths and injuries.

Medical care cost containment

Because of the staggering costs of road-related trauma are borne by all members of society in the forms of welfare payments, social security benefits to survivors, increased insurance premiums and long term medical care and rehabilitation costs, it is an obligation for us as physicians to push for mandatory seat belt legislation.

> Auto accidents cause more quadriplegia and paraplegia than all other causes combined.

Resolution to be introduced

The Larimer County Medical Society plans to introduce a resolution for such legislation at the interim meeting of the Colorado Medical Society. It is our hope that such a resolution will meet with strong support from other Colorado societies, for here indeed is an opportunity for us to practice preventive medicine while also helping to play a strong role in containing the ever-increasing costs of medical care.



Bunkie Inkret, President,
Colorado Medical Society Auxiliary

Working Hand in Hand

Many times the auxiliary is referred to as the arm of the medical society. When I think of an arm, I also think of a hand which can, in a handshake, convey friendship, strength, support and encouragement. The hand can also work to help others. In a similar manner, the auxiliary, through its volunteer projects and programs, can convey these sentiments. The auxiliary members have developed a commitment to work and help their neighbors in the communities where they work and live.

During the past year I have attended numerous Colorado Medical Society council and committee meetings. From these meetings come many important policies and program plans. However, I believe, many of the plans proposed are not implemented because of lack of time and manpower. This is where the auxiliary is a great asset and ally to the medical society. This is where the true auxiliary potential can be realized. Within the organization lies a great reservoir of energy, creativity and determination. This resource can assist you in taking those well-made plans off the paper or out of the files and putting them into action in communities throughout Colorado.

We are willing to work, and can work, in the political arena. Since 1984 is an election year, this is particularly important. "Participation–'84" is AMPAC's program to encourage and support the active involvement in the 1984 presidential campaign. Through this program, organized medicine can work to promote better government and ensure that the voice of the medical profession is heard nationwide. Much time should be committed to voter registration and to campaigning for candidates who are supportive of medical issues.

Health education is an active part of our organization. The organization can implement programs coming from the CMS Public Health Council, from the Maternal and Child Health, Environmental Health and Sports Medicine committees, to name a few. The national level of the auxiliary this year is focusing on the issue of prevention of child abuse; next year the emphasis will be on prenatal and postnatal health care. The auxiliary environmental health chairman is promoting the AMA policy of "A Smoke-Free Society By The Year 2000." One of Colorado Medical Society Auxiliary's safety projects for 1984 is the prevention of sports injuries. Programs are encouraged in education on prescription drug abuse, and we are continuing our involvement in prevention of drug and alcohol abuse, especially among the youth of Colorado. Many auxiliary members are actively working with the "Chemical People" program.

As you see, we have many common goals. By working together and combining our efforts, we can have a positive effect on the way human life should be lived and cared for.

Ask your local auxiliary to help you in your programs and, in turn, do support them in their efforts. Those of you who do not have an organized auxiliary in your area should suggest to your spouse that one be formed. The CMS Auxiliary has information and help available to help you to accomplish the formation of a new organization.

To accomplish a handshake there must be two people offering their hands. I do hope one hand is extended by the Colorado Medical Society, as the other is always extended from the CMS Auxiliary. I further hope we will find in this handshake the feelings earlier mentioned: support, strength, encouragement and friendship.

Rehabilitation Groups of the American Cancer Society

Ostomy Association

With the approval of the attending physician, carefully trained volunteers who have successfully adjusted to ostomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

(Please circle #3 on Reader Service Card)

ama update

William Y. Takahashi, MD
CMS Delegate to the American Medical Association

Delegates' Report on the AMA Interim Meeting

The AMA Update is a series of editorial columns written at the request of the Colorado Medical Society by the CMS delegates to the AMA. The articles represent the opinions of the authors and do not necessarily reflect the official viewpoints of CMS or AMA.

Three hundred fifteen delegates representing state medical societies, specialty societies, service medical schools, resident physicians and medical students attended the 1983 AMA Interim Meeting.

Many actions and activities took place. Following is a summary of the highlights of this meeting.

- Margaret Heckler, Secretary of the Department of Health and Human Services, addressed the AMA House of Delegates on the government's increasing role in health care through Medicare and Medicaid programs.
- The house adopted the following policy statement on the JCAH medical staff provisions. Considerable discussion took place on this issue:

> "...that it be the policy of the AMA that the hospital medical staff may grant admitting privileges to appropriately credentialed limited licensed practitioners in accordance with state law and in accordance with the criteria for standards of medical care established by the individual hospital medical staff."

The medical staff rules should clearly delineate the physician's responsibility for patients admitted to the hospital by limited licensed practitioners and will have control of hospital privileges according to the standards set for medical care by each hospital.

- The AMA has endorsed the *mens rea* concept in narrowing the use of the insanity defense in criminal trials. This is a rational approach and will tend to decrease the time and costs involved in criminal trials. This approach will also provide greater opportunity for appropriate treatment of the mentally ill.

This stance differs from the posi-

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- ★ Personally Visit Our Congressmen
- ★ Boat on the Potomac
- ★ Tour Capitol Hill Landmarks with Former Colorado Congressman, "Mike" McKevitt
- ★ Meet with Supreme Court Justice Byron White
- ★ Discuss Health Regulations with HHS Representatives
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Price Includes Registration Fee, Air Fare, Hotel Accommodations and the Activities Listed Above (Subject to Change Prior to Registration).

For Further Information, Contact CMS Government Affairs Division (321-8590, Ext. 213)

Registration Form

Third Annual CMS Trip To Washington D.C.

Please complete and return to **CMS Government Affairs Division, 6825 East Tennessee, Building 2, Suite 500, Denver, Colorado 80224.**

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Address: _____

Telephone: _____

Enclosed find my Washington Trip registration fee of $200 per person. Please forward confirmation of my registration and final trip information to me immediately.

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AMA Report

(Continued from p. 36)

tion taken by the American Bar Association and the American Psychiatric Association, so collaborative efforts will continue.

- The house asked for further in-depth study of the report, Indemnity vs UCR, first introduced at the 1983 annual meeting. The house amended the report to support:
  a. Freedom of patients to select their source of care
  b. Freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees.
  c. A neutral public policy and fair market competition among alternative health care delivery and financing systems.
- Regarding balance billing, the house supported the right of the physician to bill the patient for the balance regardless of method of payment where permissible by law or contractual agreement.
- On the question of DRG prospective payment legislated by the government, the house endorsed the concept that any system for reimbursement of physicians' services be independent of reimbursement systems for other providers of health care such as hospitals. Also, the house opposed any expansion of the prospective payment system until it has been adequately evaluated for its impact on the quality, cost and access to medical care.
- The ethical questions posed by the concept of surrogate motherhood lead to a house approval of the report of the AMA Judicial Council:
  "The judicial council believes that surrogate motherhood presents many ethical, legal, psychological, societal and financial concerns and does not represent a satisfactory reproductive alternative for people who wish to become parents."
- The house opposed the for-profit sale of non-renewable, transplantable organs.
- The house approved a constitutional amendment to provide seats on the AMA Board of Trustees for a resident physician (voting) and a medical student (non-voting).

obituaries

Nolie Mumey

Colorado Medical Society's oldest and longest-term member, Nolie Mumey, M.D., died January 22 in his Denver home. He was 92. In addition to his long and distinguished surgical practice, Dr. Mumey was a noted historian, poet and collector.

Dr. Mumey was born February 8, 1891 in Shreveport, Louisiana of French parents. The family moved to Arkansas where Dr. Mumey, the oldest of five children, grew up. His father's veterinary practice helped spur his decision to go to medical school.

He graduated from the University of Arkansas School of Medicine in 1916. He volunteered for the Army Medical Corps in World War I and spent 18 months as an army surgeon in Savigny, France.

Before going overseas in 1917, he married Viola Lee in Little Rock, Arkansas. She died in 1942.

After the war, Dr. Mumey moved to New Mexico for his wife's health. He set up practice in Granville as the town's only physician. When his wife's health improved, the Mumeys went east where Dr. Mumey attended several teaching fellowships and earned a master of science degree from the University of Pennsylvania.

They then moved to Denver where Dr. Mumey set up his surgical practice. He became a member of the Denver Medical Society in 1924.

It was after the move to Denver that Dr. Mumey developed his deep interest in and love for Western history. Over the years he wrote more than 80 books on the subject. He also became well-known as a collector of Western books, Indian artifacts and memorabilia from his travels all over the world. His collection included one of the country's best collections of rare santos, carved religious figures of the southwest.

One of Dr. Mumey's admirers compared visits to his home or office to a trip to the museum. His many priceless artifacts included a microscope which belonged to Charles Darwin and an original slave deed.

His many other interests and skills included woodworking, photography, fishing and jewelrymaking. He was also a licensed pilot and for many years was the flight surgeon for the 120th Observation Squadron of the Colorado National Guard. In 1956 he served as a medical director for the Red Cross at a Hungarian refugee camp in Austria.

In 1943, Dr. Mumey married Ruth Hanrahan in Denver. She died in 1979 after an auto accident in which Dr. Mumey was seriously injured. On September 13, 1980, he married Nora Flynn, who has been his literary assistant for almost 40 years.

In 1976, in recognition of his service and unique achievements, Dr. Mumey received a special "Centennial Award" from the Colorado Medical Society.

He carried on an active surgical practice until the mid-1960s and was still seeing old patients in the last years of his life.

Survivors include his wife and a sister, Mary Milligan, of Fort Smith, Arkansas.

Editor's Note: for more information on Dr. Mumey, see the article by James Delaney, M.D. in the December, 1982 issue of Colorado Medicine.

1984 Interim Meeting Business Meeting Schedule

March 9, 1984 Hilton Inn South

Friday, March 9

8:00 a.m.–5:00 p.m.	**CMS Hospital Medical Staff Section** — Independence Room
9:00 a.m.–Noon	**CFMC Board of Trustees** — Fremont Room
9:30 a.m.–1:00 p.m.	**Medical Executives Group** — M-Suite 327
Noon–1:00 p.m.	**CMS Finance Committee** — M-Suite 331
1:00 p.m.	**CMS Board of Directors** — Fremont Room

Colorado Medical Society 1984 Interim Meeting

March 10–11, 1984 Hilton Inn South

Saturday, March 10

8:00 a.m.	**Registration**
8:00 a.m.	**Committee on Constitution, Bylaws and Credentials** — M-Suite 327
9:00 a.m.	**House of Delegates** — Ballroom
Noon	**Reference Committee Chairmen Luncheon** — Evergreen Room
1:30 p.m.	**Reference Committee Hearings** Board of Directors — Winter Park Room Constitution, Bylaws & Credentials — M-Suite 127 Legislation — M-Suite 131 Professional Education — Crested Butte Room Professional Relations & Medical Service — M-Suite 327 Foundation Affairs — M-Suite 331 Socio-Economics — Geneva Basin Room Public Health — M-Suite 339

Sunday, March 11

7:30 a.m.	**CMS Nominating Committee** — Evergreen Room (Open Forum to hear potential candidates)
7:30 a.m.	**Component/District Caucuses** — (location to be announced)
8:00 a.m.	**Registration**
9:00 a.m.	**Committee on Constitution, Bylaws and Credentials** — Ballroom
9:30 a.m.	**House of Delegates** — Ballroom

(Please circle #6 on Reader Service Card.)

c.m.e report



Patrick G. Moran, Chairman, Council on Professional Education; David Haggerty, Director, Division of Professional Services

The Impact of DRGs on CME and the MD

The following article, under the above title, first appeared in the October 6, 1983 issue of* The Alabama MD, *the newsletter of the Medical Association of Alabama (MASA). It was written by George D. Oetting, Ed.D., Director of Education for MASA. The CMS Director of Professional Services also attended the AMA Conference on CME noted in the opening paragraph — see report in this column,* Colorado Medicine, *December 1983.

The possible impact of the new DRG reimbursement system on CME activities, particularly at the local hospital level, was the subject of a special seminar at the AMA 11th Annual Conference on CME in Chicago on September 30–October 1.

A panel representing the perspectives of the medical school, specialty societies, hospital administration, and the medical staff speculated on changes this economic control may have on education activities of physicians.

The first effect they predicted may be less financial support from hospitals for local hospital CME programs since reimbursement for CME costs are not payable as part of DRG costs. Traditionally, most hospitals have paid for food, audiovisual costs, and incidentals related to hospital CME activities; staff members may have to share more of the financial burden in the future.

The panelist representing the medical staff also felt that hospital interest in audits as a basis for developing CME topics may lessen with more concern for documentation and admission data to insure the most lucrative DRG code. The term "CEE" (for Continuing Economic Education) was wryly used by several as the unfortunate focus for the future.

The medical school panelist felt that DRGs will slow the development of new technology since efforts here may not be fully reimbursed; likewise, it will discourage admissions for complicated cases requiring extensive expensive tests — cases where expenses will exceed the DRG rate. Also, since DRGs are not really medical diagnoses, it will add to the confusion in teaching medical students proper therapeutic and diagnostic procedures.

Frequent comments were made about the effects that DRG will have on the practice habits of physicians. Some may be positive, emphasis on cost containment, eliminating unneccessary tests, properly documenting medical records and developing better teamwork among all those involved within a particular DRG.

Perhaps the greatest concern expressed by all was the danger that the content of local CME will be dictated by institutional economic considerations rather than the scientific needs of physicians or the medical needs of patients.

Suggestions:

1. Buy all AV equipment, etc., as soon as possible.
2. Get administration involved in your CME committee work.
3. Get administration involved in the development of your CME mission statement.
4. Be prepared to use your evaluation data, audits, attendance records, etc., as a way of showing the value of CME to the hospital.
5. Be ready to justify hospital support for CME activities.

Nominations Submitted to ACCME

The Accreditation Council for Continuing Medical Education (ACCME) is about to implement a procedure for evaluating state medical societies as intrastate accrediting agencies. For example, CMS would be evaluated, using established protocols, to see how well we perform this function for Colorado and what areas may need improvement. A team of two CME experts from other states will conduct a site survey at the offices of the state medical society being evaluated. At least once a year, site survey reports will be reviewed by a special ACCME committee called the Committee for Review and Recognition of State Medical

Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation group for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit the patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

American Cancer Society
Colorado Division, Inc.
321-2464

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Societies as Accreditors of Continuing Medical Education Providers (CRR). The CRR is to consist of seven persons nominated by the ACCME Executive Committee, five of which will be chosen from a list of nominees provided by the state medical societies and two of which will be nominated from the ACCME. Terms will be staggered on a rotating basis; no state can have more than one representative at a time.

Acting on recommendation from the CMS Committee on Accreditation and the Council on Professional Education, the CMS Board of Directors has submitted the following nominations to the ACCME:

For membership on the CRR:
Franklin D. Yoder, MD, Greeley

For inclusion in the ACCME roster of potential site surveyors:
Jerry Appelbaum, MD, ... Denver
Arnold Greensher, MD,
Colorado Springs
Ralph Hall, MD, ... Denver
Michael Lubchenco, MD, . Denver
Robert Sawyer, MD, ... Denver
Franklin D. Yoder, MD, ... Greeley
Kevin Bunnell, ... Denver
John H. Waters, ... Denver
David Haggerty, ... Denver

Each of these nominees has special expertise in continuing medical education, as an accreditation site surveyor, CME director or other CME experience.

CMS Sponsors Medical Practice Workshop

CMS will sponsor a one-and-a-half day Conomikes workshop, "Introduction to Medical Practice," April 5-6, 1984. This program, successfully conducted in Colorado for several years, is geared to the needs of third and fourth year residents, especially those just getting ready to set up practice, as well as doctors in practice for six months or less. It helps new doctors get off on the right foot in all of the "business aspects" of medical practice. Watch your mail for announcements, and call us (321-8590 ext. 216-217) for more information or if you fear the mailing may have missed you.

the lobby

M. Robert Yakely, M.D., Chairman, Council on Legislation
Carol Tempest, Director, Government Affairs Division

Preview of 1984 Legislative Bills

Wednesday, January 4, marked the beginning of the 1984 legislative session with adjournment scheduled in 140 days. On the same January 4, Carol Tempest and I flew to San Diego to attend the AMA State Health Legislative meeting at which we had the opportunity to discuss upcoming battles with states who have already fought them. Council on Legislation meetings began on January 13 and will be held every Friday afternoon until the legislature begins to wind down.

On the first day of the legislative session a total of 428 requests were listed in the legislative drafting office, including bills, resolutions, and memorials. No legislator may introduce more than six bills (with the exception of appropriations bills and bills written in interim committees) and three of these had to be requested before November 1. January 13 was the final deadline for requests and February 2 the final day for introduction of a bill.

Bills introduced early that affect Colorado physicians are as follows:
SB 7 — Concerning Inclusion of Patient Package Inserts With Prescription Drugs — Sponsored by Senator Ray Peterson, (D), Denver.
SB 43 — Concerning the Printing of the Supervising Physician's Name on Prescriptions Issued By His Physician Assistants — Senator Ray Peterson (D), Denver and Jeff Wells (R), Colorado Springs.
SB 54 — Concerning Damages For Pecuniary Loss Recoverable in Wrongful Death Actions — Senator Jeff Wells (R), Colorado Springs.
HB 1010 — Concerning the Qualifications of Members of the Board of Hospital Trustees For County Hospitals — Representative Eunice Fine (R), Greeley.
HB 1012 — Concerning Temporary Licensure Under The Medical Practice Act for Physician Who Are Both Medical School Faculty Members And Graduates Of Foreign Medical Schools — Representative Betty Neale (R), Denver.

In addition, there are many bills dealing with air quality control and disposal of hazardous waste which have been forwarded to the CMS Committee on Environment for review. We urge you to contact the Government Affairs Division staff (321-8590) if you have questions.

"Participation-'84", a political effectiveness program for physicians, auxilians, and society executives was kicked off in December and will have five goals:

1. Establishment of a voter registration data base.
2. Attendance of physicians and spouses at precinct caucuses.
3. Feedback to COMPAC concerning candidate support.
4. Campaign to "Get-out-the-vote."
5. Establishment (CMS staff) of a data base for individuals who have assisted in the above activities.

It was stressed that the program is a pilot program for metro area societies but that any other society interested in pursuing these goals would be most welcome and would receive CMS staff assistance in establishing similar programs.

Committee Recommends New Resuscitation Policy

by Joe F. Turnbow, MD, Haley Ambulance Company, Denver and Frank R. Purdie, MD, Weld County Ambulance Service, Greeley

Upon recommendation of the CMS Pre-Hospital Care Physician Advisor Committee, the Council on Professional Relations and Medical Services and, subsequently, the Board of Directors have adopted the following Resuscitation Policy, more accurately a "Resuscitate/Do Not Resuscitate Policy." We recommend this policy as a guideline for protocols to be used in any/all pre-hospital care situations where a resuscitate/do not resuscitate question can come up (e.g., nursing homes, etc.)

1. The physician in the best interest of his/her patient after consultation with the patient and/or family has deemed it appropriate that the patient should not be resuscitated.

2. In such cases, the patient's comfort is of paramount interest to the pre-hospital care provider. Invasive and painful procedures are avoided if at all possible. Expensive modalities of care should similarly be kept to a minimum if the patient cannot expect to realize any long-term benefit from them.

3. All patients in cardiac and/or pulmonary arrest will be resuscitated with the following exceptions:

A. Those patients who are obviously dead and beyond any chance of resuscitation, i.e., those who are decapitated, have rigor mortis, tissue decomposition or dependent levidity.

B. Those patients in which a nurse or family member can show you a "do not resuscitate" order in writing from the patient's current attending physician. Should there be any questions to the validity of this order then you would automatically proceed with resuscitation.

C. Upon a verbal order from an attending physician who is present at the time. You must be able to verify that this person is, in fact, the attending physician who knows this patient well. Should there be any question concerning this physician then you should proceed with resuscitation and ask that person to immediately contact the emergency physician at your hospital base.

Should you receive a verbal order via radio or telephone from someone claiming to be the attending physician to not resuscitate, you should have that person call the emergency physician on duty at your base hospital. If the base hospital physician agrees with the do not resusciate then he or she will contact you by telephone or radio. You should proceed with resuscitation attempts in this case until you hear from your base hospital physician.

D. Upon an order from your base hospital emergency physician you would cease resuscitation attempts.

4. The following procedures should not be performed on no-code patients:

A. CPR
B. Intubation
C. Difibrillation
D. MAST pants
E. Lights and sirens transport

5. The following procedures may be performed depending upon clinical judgment and in consultation with the patient, his private physician, or the EMP:

A. position of comfort
B. airway control and suction
C. intravenous line for hydration and analgesics
D. Foley catheter for urinary retention
E. oxygen for dyspnea

Drug Alert Bulletins: Methaqualone — Lack of Availability and Suggested Withdrawal Regimens

As you may remember, in late 1982 methaqualone was in short supply. At that time the Rocky Mountain Drug Consultation Center provided subscribers with data about methaqualone withdrawal and its management. On November 17, Lemmon Company, the only legal manufacturer of methaqualone in the United States, announced that it had halted the manufacture of the drug and would discontinue its distribution by January 31, 1984. Because of this development, we feel it worthwhile to repeat the following drug alert bulletin.

Methaqualone produces withdrawal symptoms very similar to those of barbiturates and can be life-threatening. Physical dependence with withdrawal symptoms has been reported in patients receiving 1500 mg daily or greater (R Ewart and RG Priest, Br Med J 3:92, 1967; M Schwartzburg et al, Arch Gen Psychiatry 29:46, 1973). However, lower doses may also produce dependence. Withdrawal symptoms are similar to those of barbiturates and include tremors, weakness, restlessness, diaphoresis, delirium tremens, hallucinations, fever and convulsions.

Patients receiving doses more than 900 mg daily of methaqualone should be considered candidates for withdrawal with phenobarbital or benzodiazepines. Phenobarbital is used for treatment of methaqualone-induced withdrawal symptoms because of its long half-life (approximately four days) and ability to produce more constant serum concentrations than shorter acting barbiturates (secobarbital, pentobarbital). Euphoria also appears to be less with phenobarbital. To initiate withdrawal, 30 mg phenobarbital should be administered in place of each 250–300 mg methaqualone, and should be started in daily divided doses. This equivalent dose of phenobarbital should be maintained for a minimum of two days, after which gradual withdrawal at a rate of 30 mg daily is indicated (GC Hodding et al, West J Med, 133:33, 1980). Thus, a patient receiving methaqualone in doses of 1500 mg daily should be initiated on phenobarbital 150 mg daily in divided doses and then tapered as indicated. There is no exact "equivalent" with the benzodiazepines, but diazepam 5–10 mg every four to six hours should be sufficient for treatment of most patients, with dose adjustments made upon clinical response.

Physicians and pharmacists are encouraged to call the Rocky Mountain Drug Consultation Center for more information about methaqualone addiction or any drug information questions.

Tardive Dyskinesia

Recent media coverage of tardive dyskinesia, its etiology, characteristics and treatment, has increased consumer and health professional interest in this topic.

Tardive dyskinesia (TD) is a neurological side effect seen in susceptible individuals receiving neuroleptic therapy. It is characterized by lingual-facial hyperkinesias (i.e. smacking and licking of lips, sucking or chewing movements, rolling and protusion of the tongue, blinking, grotesque grimacing, spastic facial distortions), choreoathetoid movements of extremities (i.e. chronic jerking of fingers, ankles and toes) and tonic contractions of neck and back muscles. These symptoms occur late in drug therapy, generally three to six months after onset of therapy.

The reported incidence of TD has varied widely in the literature, ranging from 0.5% to 65% of treated patients (Asnis et al, Am J Psychiatry 1977;13467-70; Crane, Br J Psychiatry 1973;122:395-405; Simpson et al, Psychopharmacology 1978;58:117-24).

This variablity is probably due to nonstandardized evaluation of the symptoms. The prevalence of TD has only been weakly associated with the type of phenothiazine or total cumulative dose (Crane, Am J Psychiatry 1968;124:140-8; Perris et al, Br J Psychiatry 1979;135:509-14; Crane & Smeets, Arch Gen Psychiatry 1976;30:341-3; Smith et al, Am J Psychiatry 1978;135:1402-3). Evidence suggests that use of anticholinergics may exacerbate the dyskinesia.

The etiology of tardive dyskinesia is thought to be dopamine receptor hypersensitivity (Simpson et al, Drugs 1982;23:381-3). Many dopamine agonists and antagonists have been utilized clinically to control TD; however, these agents only appear to mask TD temporarily, and in relatively advance cases of TD, symptoms will worsen as further hypersensitivity develops (Freeman, Br J Psychiatry 1979;135:82-3; Casey & Denney, Psychopharmacology 1977;54:108).

Tardive dyskinesia has been shown to reverse or improve with early diagnosis and reduction of neuroleptic dose or discontinuation of the neuroleptic (Quitkin et al, Proc Am Psychiatric Assoc 1982;68D:171; Wegner & Kane, Am J Psychiatry 1982;139:368-9; Urhbrand & Baurby, Psychopharmacologia 1960;1:408-18). Lingual-facial movements are frequently observed first. Patients on neuroleptics should be monitored closely for the development of these symptoms.

The managment of patients with TD is not clear-cut. The relative risk versus benefit to the patient must be considered. If psychiatric status permits, the neuroleptic should be withdrawn (one-third of total dose/month) as well as all anticholinergic agents over a two-three week period (Simpson et al, Drugs 1982;23:381-93). During this withdrawal period, dyskinesias may occur which can be treated with diazepam. If the dyskinesias are severe, a neuroleptic may need to be given.

At present, it is impossible to predict susceptible patients, severity and reversibility of symptoms; prevention is an important clinical goal.

BME Adopts Rule on Stimulant Drugs

At a meeting on January 12, the Board of Medical Examiners unanimously adopted a rule designed to stem the flow of stimulant drugs, particularly amphetamines, to the illicit street market. The new rule is based on policies developed by the Colorado Medical Society and Denver Medical Society. It places strict limits on prescriptions of stimulant drugs, designated as Schedule II controlled substances. Among other purposes, the new rule will virtually bar the prescription of amphetamines for weight control.

The policies adopted by the medical societies grew out of concern about the widespread abuse of these drugs. The CMS policy was adopted by the board of directors at the board's December meeting and must be ratified by the CMS House of Delegates at their spring meeting. The policy includes guidelines for prescription of stimulant drugs. These guidelines were published in the December issue of *Colorado Medicine*.

Bar Soaps May Be Germ Reservoirs

Researchers have reported that common bar soaps in normal conditions can become reservoirs for microorganisms which may be harmful, particularly to the aged, newborn infants, immunosuppressed individuals and others who are considered to be at high risk for infection.

These scientists say that bar soaps, under normal conditions, may represent a public health hazard. Liquid soaps in disposable containers are a less likely source of infection when adequate quality control measures are instituted.

This research was conducted by scientists at the Department of Biomechanics at Michigan State University Medical School. Findings have been published in a recent issue of the *Journal of Environmental Pathology, Toxicology and Oncology.*

According to the study, bar soaps may become contaminated by handling as well as by airborne microorganisms spread by sneezing, coughing, air conditioning systems and flushing toilets. Bar soaps in normal use may become sources of infection and re-infection, as well as sources of cross-infection in communal situations.

Over a four-week testing period, the researchers found more than 100 strains of bacteria, yeast and fungi on bar soaps. No organisms were found in the liquid soaps tested.

Mildred Doster Receives Award

Mildred Doster, MD, received the A.H. Robbins Award for Community Service at the January 6 meeting of the CMS Board of Directors. She was presented with the award by John A. Whitesel, MD, President of the Colorado Medical Society.

Dr. Doster has long been active in community public health and health education. For many years she was Assistant Director of the Denver Public Schools Health Division. Among other activities, she has been chairwoman of the Colorado Heart Association and the CMS Council on Public Health.

She sits on the boards of several nursing homes and is actively involved with senior citizen advocacy programs. Dr. Doster has received many other awards for her community service, including the Florence Sabin Award from the Colorado Public Health Association and was named in 1983 as one of the "women of the year" by the Big Sisters of America.



Mildred Doster, MD

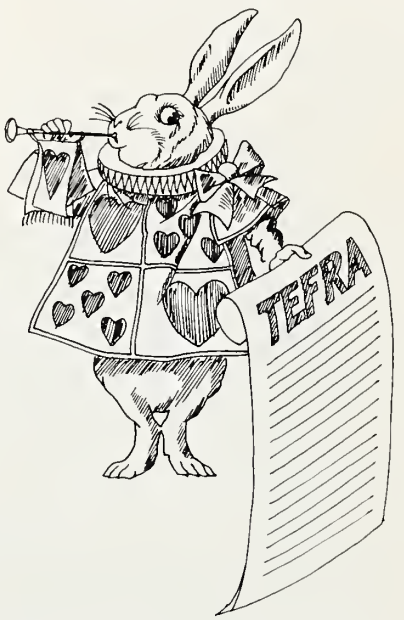
Physicians in Wonderland: Making Sense of the New Economic Reality

As Humpty Dumpty said, which is to be master? Is the private fee-for-service physician out of date? Should he or she consider joining one of the alternative health care delivery systems, and if so, which one? Who will be in control, the physician or the marketplace? This article is the second in a two-part series which discusses some of the major questions facing the private physician today, in particular the development and implications for physicians of PPOs and IPAs in Colorado. The author is David Hlavac, CMS Director of Medical Economics and Professional Relations. (The quoted references set off in bold-face type are, of course, from Lewis Carroll's **Alice's Adventures in Wonderland *and* Through the Looking Glass.)**

"'The time has come,' the Walrus said, 'to talk of many things; of shoes and ships and sealing wax...'" and PPOs and things. (With apologies to Lewis Carroll.) To the physician perusing the present health care system with an eye toward economic survival, the scene may appear reminiscent of Alice's excursion through Wonderland. What once seemed to make sense has now become a confusing array of organizations and acronyms purporting to promote increased competition and health care cost containment. TEFRA, DRGs, HMOs, PPOs, to name a few, have emerged in response to what is considered an untenably rising slope in the curve of health expenditures.

While rumors of the demise of fee-for-service medicine have surfaced periodically for quite some time, developments over the past several years may be pushing those rumors toward reality. As the purchasers of health services begin to flex their economic muscles, as alternative delivery systems encompass a larger share of the patient market, and as the ever-rising supply of physicians induces greater competition, further modification of the current system is inevitable.

In Colorado, developments in a variety of areas indicate the transformation that is occurring within medicine. Jerry Peters, of Byerly & Company, an independent insurance consulting and brokerage firm, finds the situation analogous to the opening of the Oklahoma territory at the turn of the century — conveyances of every description are poised at the starting line hoping to carve out a niche of the territory, but it remains to be seen just which will be successful.



"Consider your verdict," said the King. "Not yet, not yet" the Rabbit hastily interrupted. "There's a great deal to come before that!"

PPOs

Preferred Provider Organizations, PPOs, are one of the vehicles for promoting cost competitive health care that have emerged in recent years. PPOs, as indicated in a previous article, are contractual arrangements between purchasers of health services and providers, which offer health benefits on a fee-for-service basis at negotiated (frequently discounted) rates, and are marketed to patients with free choice of providers, but usually include financial incentives for using selected providers. Growth in the number of PPOs in Colorado has been fairly rapid. Tobie Miller, Administrator for Mountain Medical Affiliates, a PPO affiliated with Presbyterian-St. Luke's Hospital, says that, outside of California, Colorado has more operational PPOs than anywhere else in the country.

Presently there are six operational PPOs in the Denver Metropolitan area, and three in Colorado Springs. At least two more are in the developmental stage in the Denver area. All are affiliated with, or in some cases sponsored by, area hospitals, although the separation between the physician providers and the hospial is contractually maintained. Over 1,000 physicians are contracted to one or more of the PPOs. The degree of physician vs. hospital control varies among the PPOs.

It is estimated that some 350,000 individuals are currently eligible PPO utilizers, though there is some duplication and overlap among the target populations shared by the PPOs. Sam Jenkins, Executive Vice President of Martin-Segal Associates (an insurance consulting and actuarial firm), and generally acknowledged as one of the originators of the PPO concept, projects that the eventual market share for PPOs in Colorado could top one million.

PPOs compete in the market through the provision of discounted physician and hospital fees and the

potential for decreased hospital utilization. Discounting of physician fees varies considerably among the Colorado PPOs, ranging from 5 percent to as high as 40 percent in some instances. Generally the discounts average approximately 20 percent from usual and customary physician charges.

Critics of the PPO arrangements claim that the discounted fees will be more than made up in increased utilization. To date, however, there is no evidence to either support or refute the claim. All of the PPOs in Colorado have some mechanisms for peer review and quality control. Most typical is some form of concurrent review of hospital length of stay. Several have implemented preadmission authorization and mandatory second opinion programs as well. A few require certain procedures to be performed on an outpatient basis.

Nearly all of the PPOs are moving in the direction of more stringent utilization controls. Most are collecting baseline data that will allow profiling of services provided in the physician's office as well, and it is likely that at some point, physician office services will come under some type of review.

A recent article in the New England Journal of Medicine, recounting the failure of SAFCO, an IPA-type HMO, concluded that the absence of strong controls on utilization from the start of the program contributed heavily to the organization's eventual demise. While many physicians find the requirements for screening of their practice patterns onerous, the PPOs rely on the doctors' willingness to go along with such review in order to hold down utilization and make the plans more marketable and competitive.

As the number of participating physicians would seem to indicate, acceptance of the PPO concept in Colorado is quite high. Dr. Henry Cleveland, Medical Director of the Sloan's Lake Medical Group PPO, feels that it is medicine's obligation to respond actively to the need for cost control, and sees PPOs as a responsible alternative. Fears persist, however, among some physicians who feel that the emphasis on cost reduction will result in lower quality of care. They also view PPOs as a threat to the physician's traditional autonomy, and see that concept as a wedge that will eventually serve to divide and fragment the physician community.

While existing PPOs in Colorado are all provider-sponsored, there is indication that the insurors are interested in the concept as well. Mr. Peters states that at least three large nationwide insurance companies are exploring the feasibility of PPOs in Colorado. Of the three, Equitable, Prudential and Mutual of Omaha, only the latter has demonstrated any active interest thus far. The insurors are investigating the potential for nationwide networks of PPOs that will provide greatly expanded coverage for enrollees and their families.

David Sheehan, Senior Vice President for External Affairs for Blue Cross and Blue Shield of Colorado indicates that his organization is also seriously pursuing the PPO concept. He states that the "Blues" see PPOs as a feasible alternative for reducing the rate of increase in medical care costs, although there has been no time frame set for actual development of a PPO by Blue Cross and Blue Shield. Mr. Sheehan notes that "any programs that stick just to price discounting won't make it. There is a need for good utilization review systems and economic incentives to make them work."

Mr. Sheehan's reference to economic incentives indicates the strong likelihood that eventually PPOs will move toward a greater degree of risk sharing with their enrolled providers. Up to now, participation in the PPOs has been relatively risk-free for the physicians. As PPOs continue their evolution into what has been termed "second generation" PPOs, however, there is likely to be an increase in the development of "risk-pools" and capitated arrangments among the PPOs. The Independent Hospital Group (IHG), a network of five area hospitals in and around Denver, is investigating the feasibility of an alternative delivery system that may incorporate the elements of both the current features of the PPO concept as well as the provision for shared risk.



"Would you tell me, please, which way I ought to go from here?" said Alice. "That depends a good deal on where you want to get to."

IPAs

In a parallel, but distinctly different track to the burgeoning of PPOs, a number of county medical societies in Colorado are beginning to develop independent practice associations (IPAs).

The IPA model incorporates physicians into a (usually) non-profit organization, with a set of by-laws and governing board. Physicians contract to provide services on a fee-for-service basis, with a portion of their fees retained in a risk-pool. The IPA contracts to provide services to a defined population for a fixed periodic sum per enrollee. If utilization and costs fall within the range projected, the risk-pool is distributed to the physicians at the end of the period. If utilization exceeds the predicted amount, the physicians are at risk for the excess costs.

Edgar Smith, an independent consultant and former medical society executive who has assisted the county societies in the development of IPAs, feels that IPAs provide greater flexibility and more protection of the physicians' interests than do PPOs. Mr. Smith was instrumental in setting up the state's first free standing IPA, Health Care South (formerly the Arapahoe Health Plan) sponsored by the Arapahoe Medical Society which serves as the model for the emergent organizations. "The IPA is the most powerful vehicle available to physicians," he says. Since they are "at risk" organiza-

tions, they may engage in bargaining and fee negotiation with less threat of anti-trust scrutiny than is afforded in the PPO arrangements. In addition, the IPA model can be structured to incorporate the PPO selective contracting arrangements if the organization so chooses. "We can do all the PPO can, but the PPO can't do all we can," Mr. Smith states.

The Future

The Denver Medical Society, which has consulted with Mr. Smith, has recently organized the Denver Medical Practice Association. According to the Executive Director of the DMS, Peter Morstad, the IPA model will serve the physicians' and patients' interests better than the PPO. "By and large, PPOs are funded and controlled by institutions (hospitals). They are protecting a market share," in Mr. Morstad's view. He sees the IPAs, however, as a means of maintaining the concept of quality medical care and reducing overall cost increases while upholding the physicians' economic interest. "The IPA doesn't discount," he says, "It puts physicians in a position of shared risk, which is what business and government really wants." The IPA will also incorporate strong utilization and peer review controls, but Mr. Morstad feels that these will be generally accepted by the doctors as a necessary feature in controlling costs.

In addition to Arapahoe and Denver, the county medical societies in Clear Creek, Aurora, and Boulder are also exploring the development of IPAs/PPOs. Eventually some form of networking arrangement is anticipated in order to provide more geographic dispersion of providers and increased accessibility for enrolled patients.

Up to now, the business community has been slow to respond to the alternatives presented by PPOs and the IPA/PPO concept. There has been some skepticism concerning the demonstrated effectiveness of the PPO arrangement in the area of cost containment. Employers are also somewhat reluctant to tamper too vigorously with their employees' benefits. It appears, however, that support for the concept is beginning to grow. Most of the contracts with PPOs presently involve Taft-Hartley trusts — management/union health and benefit trust funds exempted by federal statute from state insurance commission oversight. Self-insured employers make up the bulk of the remaining PPO contracts.

Some of the larger employers, such as Adolph Coors and CF&I Steel, have set up self-administered plans. Coors, for example, currently has contracted with about 1,000 physicians in the Denver metropolitan area to provide services to their employees. They have developed their own allowable (non-discounted) fee schedule based on the Blue Cross and Blue Shield relative value system. The contracts stipulate that physicians will accept Coors reimbursement as payment in full for any services delivered. The fee schedule appears to be one of the more liberal reimbursement systems in the area. Coors indicates that both the employees and the physicians appear to be satisfied with this arrangement. Although they are currently collecting information for a data base, there are no plans at this time to change the system, according to Dale Wydman, the insurance director for Coors.

Contracting

The growth of selective contracting is likely to continue in Colorado, and raises several concerns that will need to be addressed as the new organizations evolve. While the IPA arrangement is defined and covered by both federal and state statute, there are no such regulations governing PPOs. Colorado insurance law is silent about PPOs, and no legislative changes affecting this are currently anticipated. As the so-called "second generation" PPOs begin to develop with provisions for risk-sharing, they may fall within the purview of the Colorado insurance regulations.

Federal anti-trust scrutiny is another area of concern for the developing organizations. The issues of price-fixing and restraint of trade have not been leveled at PPOs thus far. However, as the organizations begin to proliferate and assume new forms, there is no guarantee that they will not capture the attention of the Federal Trade Commission. In a recent publication on PPOs, the American Medical Association has stated that, "Groups or organizations of independently competing physicians that combine in a PPO arrangement to negotiate contracts or use relative value scales to determine fee schedules expose the PPO and its members to a significant risk of anti-trust liability." The risk of anti-trust scrutiny is dependent upon such factors as the method of organization, how the fee schedule is negotiated, and the extent of the market share covered by the arrangement. Since the government has tended to look favorably upon PPOs so far, there does not seem to be cause for any immediate alarm. However, physicians will want to keep these considerations in mind when contemplating contracting with a PPO or any similar organization.

Since the arrangements discussed throughout the article involve entering into contracts, contracting is perhaps the most significant of the issues for physician consideration. When evaluating the decision to participate in an IPA, PPO, or any other contractual arrangement, it is important that a physician be aware of the binding obligations it imposes upon him. Physicians should carefully review all of the terms and implications of the contract. In addition, it would be wise to investigate the track record of the organization

(Continued on p. 55)



Where the noise came from, she couldn't make out: the air seemed full of it, and it rang through and through her head until she felt quite deafened.

Patients' Access to Medical Records

Ed. Note: In response to requests from CMS component societies, we are reprinting two articles that were first published in Colorado Medicine in June and July 1980. These articles were written by Brian Stutheit, an attorney and former staff member at the Colorado Medical Society.

Colorado law mandates access to patient records in the custody of a health care facility or in the custody of individual health care providers. Patient records do not include a doctor's office notes.

Patients who want to inspect their records must submit a written request, dated and signed, at reasonable times and upon reasonable notice. If the patient wants a copy of the records made available to himself or his designated representative he must again submit a written authorization, dated and signed by the patient.

In addition, the physician may require payment of reasonable costs for the copies. The Colorado Department of Health has issued regulations interpreting the access-to-records law which define reasonable cost: "The patient or representative shall pay for the reasonable cost of reproduction of his/her patient record, not to exceed $5.00 for the first 10 or fewer pages and $.25 per page for every additional page." For special records, like x-rays, the physician may charge the actual cost of reproduction.

In most cases, a minor's parent would be considered the natural guardian and thus should be allowed to see the child's record. See the exceptions, not exclusive, below.

Individual physicians need not grant access to records pertaining to psychiatric problems or to records that would have a significant negative psychological impact upon the patient, but may be required to make available a summary of those records. Similarly, the law is not construed to require the release of records of diagnosis and treatment of venereal disease or drug addiction of a minor patient to his parents or guardian.

Requests by patients for inspection of their medical records should be noted with the time and date of the request and the time and date of inspection.

The position of the Colorado Medical Society Grievance Committee and the AMA Judicial Council is that it is improper to withhold patients' records on the basis of nonpayment of bills. There are other means of collection and the public relations damage from this type of action outweighs any advantages accruing on an economic basis.

Special federal rules apply to alcohol and drug abuse records kept in connection with a federally-assisted function.

Senate Bill 91, which became law in 1976, authorizes committees of the state medical society to request written permission from physicians to examine charts for the adequacy of medical care.

By Colorado law, patients may have access to their medical records.

Retention

By regulation, patient records in the custody of a health care facility must be retained at least 10 years. Minors' records are retained longer. There is no such requirement for records preservation by individual health care providers.

The statute of limitations for negligence, breach of contract or lack of informed consent suits is an important consideration in record-keeping by individiual physicians. It is important to consult an attorney to tailor a retention schedule to fit particular needs.

As a general rule, suits against Colorado physicians for negligence, breach of contract or lack of informed consent must be instituted within two years after the person bringing suit discovered, or reasonably should have discovered, the injury. An action may not be instituted more than three years after the injury, regardless of time of discovery.

However, there are numerous circumstances in which the time limit is extended. For example, if the suit is filed by patients who were minors at the time of the act or omission leading to the suit, then the period may be extended. If a foreign body was left in a patient, the statute may be extended. A physician's concealment of an act or omission may extend the statute of limitations. These intricacies account for the need to consult an attorney about retention.

If storage is a problem, reproducible microfilms may be made of the records. There are companies which will photograph and store such records.

Under both state regulation and as a condition of Medicare participation, hospitals are required to have a medical records department which will preserve patient records at least ten years after the patient has had his last treatment at the hospital. Hospitals are understood to own the records themselves and to be custodians over the information in records, with a responsibility to safeguard records against loss and use by unauthorized persons. However, they are also obliged to release records to patients who show a legitimate interest in their

use.

Hospital patients may see their records or obtain copies under much the same procedure as for records in an individual physician's custody. The Colorado law on patient access does not explicitly protect doctors' "notes" that appear in a hospital record. This is in contradistinction to the law on records in the hands of individual practitioners which protects "doctors' office notes." The department of health has concluded, therefore, that doctors' notes are subject to disclosure once entered into the hospital chart. The obvious lesson is that individuals entering a hospital record must use appropriate language. It is also obvious that hospital records are subject to wider review than records in an office. The hospital may let a whole range of support personnel use the record. The medical staff may evaluate records for timely completion and quality of care (See Colorado Senate Bill 91, 1976). Infection Control and other committees might have access.

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Physician-Patient Privilege

Colorado has a statute (13-90-107, 1979 Supp.) which says that a physician or surgeon may not be examined without the consent of the patient about any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient. This statutory privilege is less broad than may be commonly understood.

The privilege applies to judicial or quasi-judicial proceedings. It does not apply across the board. Indeed, the law states specifically that the privilege does not apply to the following:

1. A physician sued by or on behalf of the patient or his heirs on any cause of action connected with the physician's treatment of the patient.

2. A physician who was in consultation with the physician sued.

3. A review of a physician's services by any of the following:
(a) the governing board or medical staff of a hospital where the physician practices, pursuant to written bylaws
(b) an organization authorized by federal or state law or contract to review services or an organization which reviews the cost or quality of physicians' services under a contract with a group health care program
(c) the Colorado State Board of Medical Examiners
(d) a peer review committee of a medical society whose membership includes not less than one-third of the MDs or DOs licensed in Colorado. The subject physician must be a society member and have signed a release authorizing review. This essentially is the provision under which the CMS Risk Management Committee operates.

4. A physician or any health care provider who was in consultation and who may have acquired information or records relating to the services performed by the physician as specified in 3, above.

The privilege belongs to the patient. If the patient expressly or implicitly waives the right to nondisclosure, then the physician may not invoke it.

Records as Source of Payment

Institutional records are called upon regularly by third party payers as a source of service review and claims processing. This area poses great problems for institutions because so many interests conglomerate, often with disparate needs. The physician may have an interest in the record. The patient does. The third party payer's needs do not necessarily correspond to those of the patient or physician. On top of its obligations to each of the other parties, the institution may have its own economic needs rolled up with the records.

Because the area is too complex for the space allotted here, I will discuss only release of information to Medicare and Medicaid.

Federal law on Medicare and Medicaid conditions reimbursement upon access. The agencies involved and fiscal intermediaries may review the records without patient consent as long as the use is pertinent to the reimbursement program. The question of the inherent right of government or intermediaries to see records is usually made moot by the fact that beneficiaries sign forms specifically consenting to release.

Grievance Committee, Board of Medical Examiners

The Colorado Medical Society Grievance Committee occasionally requests records in order to investigate a complaint. The records are obtained by having the patient or complainant sign an authorization for record review. Records thus obtained are used only for the purposes of the grievance committee and contents are not disclosed to third parties.

Sometimes, but very rarely, the records are forwarded to the CMS Judicial Council for a full hearing or to the BME. The BME is notified when the nature of the alleged offense is such that the committee cannot deal with it, e.g. a claim of manslaughter, or when the investigation leads to a belief that the physician has engaged in unprofessional conduct, i.e. proscribed by the Colorado Medical Practice Act.

The grievance committee records are immune to a subpoena in any civil suit against a physician and the committee's records are exempted from "any law requiring that . . . minutes or records of the committee with respect to action of the committee taken pursuant to the provisions of this article (CRS 1973, 12-43.5d102, 1978 Repl. Vol.) be open to public inspection.

The BME may request a summary of the findings, recommendations and disposition of grievance committee actions. This is also true of medical staff reviews and the actions of a hospital board in response to recommendations of one of its review committees.

Ed. Note: The following is excerpted from Opinions of the AMA Judicial Council, 1981.

Records of Physicians on Retirement

In addition to legal requirements, there may be good reason why a physician would wish to preserve his records for some time. In many instances, the patient must rely on his physician and his physician's records to establish the fact that he did receive medical care and treatment or that he has had the services of a qualified physician. Without the (previous) physician's records, the physician who rendered the care would be unable to assist his patient. Thus, in the best interests of the patient, the physician should not indiscriminately dispose of his records, but should give consideration to the type of practice he has and to the possible needs of his patients.

Sale or Purchase of Physician's Records

Ethically, a physician retiring from practice may not sell his patient's records to another physician. His records have been developed during the physician-patient relationship. To sell records would tend to make the patient subject to barter to the highest bidder. For the patient's benefit, however, but only with his consent, these records may be transferred to a physician of his choice. A reasonable charge for secretarial or duplicating service connected with such transfer is not improper.

A physician ethically may not purchase patient records, as such, from a retiring physician or from the estate of a deceased physician.

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Drug Therapy Questions and Answers

This column is designed to provide Colorado physicians with specific answers to commonly asked questions about drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All Questions published in the column were generated from calls received by the Rocky Mountain Drug Consultation Center. These calls came from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions. The center is open from 8 a.m. to 5 p.m. Monday through Friday, with 24 hour on-call service. The director of the center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine at the University of Colorado Health Sciences Center. The medical director is Earl Sutherland, MD, Ph.D., Assistant Professor of Medicine at UCHSC. The following articles were written by Susan C. Smolinske, BS, R.Ph.

The New Drug Orphan Law

Request:
Which drugs fall under the orphan drug classification?
Response:
The high cost of pharmaceutical research and lack of commercial profitability have deterred many manufacturers from pursuing FDA approval for un-patentable drugs for rare diseases. The Orphan Drug Act, which was signed into law on January 4, 1983 is designed to provide monetary incentives to sponsoring companies to defray the cost of research.

The law established a new Orphan Products Board within the Department of Health and Human Services which will identify orphan products and promote sponsorship. Rare disease is defined by the law as any which occurs so infrequently in the United States that there is no reasonable expectation that the cost of drug development will be recovered from sales in the United States.

The Orphan Drug Act provides for five years of 50 percent tax credits totaling $75 million to drug companies for clinical testing; grants totaling $4 million to individuals or non-profit groups; a seven-year exclusive testing license to the first qualified sponsor of an orphan drug and a more flexible NDA review process.

The new law will stimulate the approval of drugs used for rare diseases, particularly those which are un-patentable. Below is a list of orphan drugs.

Drug	Manufacturer	Indication
amiodarone	Ives	cardiac arrhythmias
bacitracin	Al Laboratories	pseudomembraneous colitis
carnitine	McGraw	primary carnitine deficiency
deprenyl	confidential	Parkinson's disease
ethanolamine oleate	confidential	bleeding esophageal varices
haematin	Abbott	acute hepatic protoporphyria
hydroxyethyl starch	Am Crit Care	WBC harvesting
indium[111]oxine	Medi-Physics	WBC and platelet imaging
L-5 hydroxytryptophane	Bolar	post-anoxic myoclonus
methacholine chloride	Roche	diagnosis of occult bronchial asthma
NP-59	Mallinckrodt	adrenalcortical imaging
pimozide	McNeil(NDC submitted)	Tourette's syndrome
pentamidine	Zenith	Pheumocystis carinii
trien(triethylenetetramine)	MSD	Wilson's disease
vitamin E inj	Roche	neuromuscular disorders secondary to vit E deficiency

Continuous Morphine Infusions

Request:
What guidelines should be followed when administering continuous narcotic infusions to terminally ill patients?
Response:
Continuous intravenous narcotic infusions were used routinely in 58 percent of 97 hospitals surveyed in one study (Menard, 1982a). The most common indications for continuous therapy were patients with terminal malignant disease (66 percent), preterminal malignant disease (43 percent), nonmalignant chronic pain (30 percent) and acute postoperative pain (14 percent). The specific narcotic used was usually morphine sulfate, but other narcotics were also used (hydromorphone, meperidine, methadone, fentanyl, levorphanol).

Continuous narcotic infusion has several advantages over oral or intermittent parenteral therapy in chronic pain patients. Fluctuation in

pain relief is avoided, dosage adjustments are facilitated and the total daily dose may decrease (Rutter et al, 1980). Some clinicians feel that tolerance to analgesic effects develops more slowly in patients on continuous infusions.

Continuous subcutaneous morphine infusion is a fairly recent technique which allows ambulatory outpatient care with the same advantages as intravenous therapy. Portable pumps (Auto Syringe Model AS2F) used for continuous insulin therapy are adapted for this use, with the bolus button disarmed to avoid accidental or deliberate overdose. A 27 gauge butterfly needle inserted into the subcutaneous tissue of the abdominal wall is connected to the pump with 20–40 cm of plastic tubing, which is changed every other day. Complications observed following doses of 75–450 mg/24 hours include occasional hallucination, gradual sedation and respiratory depression and local skin erythema and infection (Minow et al, 1981; Campbell, 1983).

The establishment of guidelines for the use of continuous narcotic infusions is essential. The following summary of recommended protocols may be helpful in devising individual hospital guidelines.

Morphine Infusion Protocol

A. Indications (Menard, 1982a)

1. Inability to swallow or tolerate rectal therapy.
2. Intractable vomiting or GI obstruction.
3. Inability of routine administration of po or intermittent parenteral therapy to control pain.
4. Diminished muscle mass resulting in painful or nonabsorptive sc or im injections.
5. Coagulopathy leading to severe local burning and ecchymoses after sc or im injections.

B. Medication History (Cohen, 1981)

1. The patient's age, height, weight, reason for analgesia and history of previous narcotic use should be recorded.

C. Solution Preparation

1. Cohen (1981) recommends initial solutions of either 50 mg/250 ml or 100 mg/500 ml of D5W; final concentration 0.2 mg/ml.
2. Ensworth (1979) used an initial solution of morphine sulfate 240 mg (16 ml of 15 mg/ml solution), chlorpromazine 50 mg (2 ml) and D5W 482 ml; final concentration 0.48 mg/ml.
3. In a patient requiring extremely large amounts of morphine, Ensworth (1979) modified the solution to contain morphine sulfate 2400 mg (160 ml), chlorpromazine 12 ml, promethazine 400 mg (16 ml) and D5W 312 ml — final concentration 4.8 mg/ml.
4. Holmes (1978) dissolved powdered morphine sulfate 500 mg in sterile water, filtered with a 0.22 micron filter and added to 500 ml D5W; final concentration 1 mg/ml.
5. Menard (1982b) recommends the use of two different infusions for security reasons; 100 mg in D5W (1 mg/ml) for patients requiring 1–10 mg/hr and 250 mg in D5W (1 mg/ml) for patients requiring more than 10 mg/hr.
6. Although published documentation is available only for use of morphine concentrations up to 4.8 mg/ml, patients with extremely large dosage requirements may occasionally need the use of higher concentrations to avoid fluid overload.

D. Dosing/Administration — Adult (Cohen, 1981)

1. The physician should administer the loading dose by slow IV infusion at a rate of 2 mg/minute until pain relief occurs. Normal loading dose is 15–20 mg but larger amounts may be necessary in chronic pain patients.
2. Initial maintenance dose is 2 mg/hr in patients with acute pain or no history of recent narcotic use and 5 mg/hr in patients with chronic pain.
3. Rate changes should be based on physician or nurse assessment of comfort beginning with hourly vital sign monitoring. The infusion is increased in increments of 1 mg/hr until adequate analgesia is maintained. Doses as high as 275 mg/hr have been used for as long as four days. Somnolence attributed to the chlorobutanol preservative in the morphine solution necessitated reduction of the dose to 150 mg/hr in this patient (DeChristoforo et al, 1983).
4. Usual maintenance dose ranges from 0.8–80 mg/hr.
5. Cohen (1981) suggests attaching a morphine dosing chart to the infusion pump to avoid dosing errors.

E. Dosing/Administration — Pediatric

1. Miser et al (1980) administered morphine in dextrose-saline solution through an infusion pump to children aged three-16 years with chronic pain due to malignancy. The initial dose was based on analgesic requirements over the preceding 24 hours.
2. Maintenance doses of 0.025–2.6 mg/kg/hr provided complete relief of pain. The median dose was 0.04–0.07 mg/kg/hr. Respiratory depression necessitating dose reduction was observed in three of eight children.

F. Monitoring Parameters (Menard, 1982b; Cohen, 1981)

1. Blood pressure — monitor and record every five minutes during loading; every 15 minutes for the first hour; every hour for four hours and every four hours thereafter and as ordered by the physician. If diastolic blood pressure decreases by more than 10 percent, the infusion should be discontinued and the physician notified.
2. Respiratory rate — monitor and record along with blood pressure. If less than 10/minute, the infusion should be discontinued.
3. Mental status — monitor and record.
4. Oxygen requirements — monitor and record.
5. GI status — monitor and record.
6. Reassessment should be made by physician every 12 hours for continuation of infusion.

G. Precautions (Kowolenko, 1980)

1. Narcotic antagonists are contraindicated in chronic pain patients and may result in sympathetic crisis due to precipitation of withdrawal and recurrence of pain. Respiratory depression should be treated mechanically.
2. Infusion pumping devices should be able to signal the nurse if obstructed or if rate change occurs.
3. Use with caution in patients with increased intracranial pressure, chronic obstructive pulmonary disease, atrial arrythmias, severe

(Continued on p. 55)

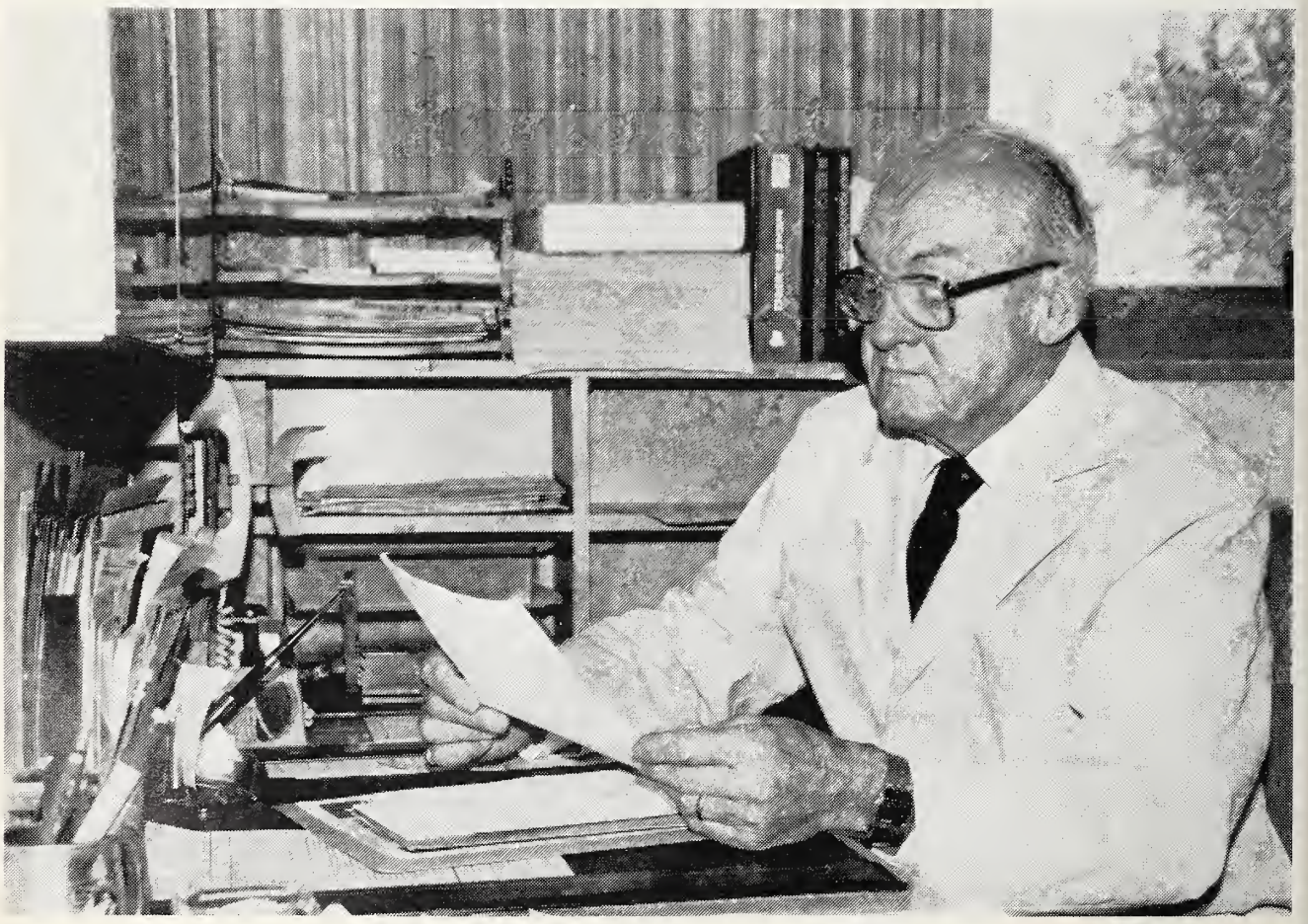
Frank McGlone

by James J. Delaney, Jr., MD, Historian, Colorado Medical Society

Seventy-year-old Frank McGlone, MD, one of Denver's best known physicians, took some time out recently to reminisce about his long and interesting practice in Denver. At a time when many people his age are enjoying the fruits of their labor by relaxing a little, Frank is still active full time in practice. He has made some concessions to time by not seeing hospital patients. He spends about one-third of his time seeing patients, primarily geriatric, at the Denver Clinic; another third in community and national service work; and the remaining third of his time with his Medical Research Foundation.

Frank was born May 5, 1913 in Denver, the youngest of seven children. He had four brothers and two sisters. His family migrated to Denver from Nebraska by covered wagon in about 1905. His father worked as a bookkeeper for a grain company. His family was poor but close and the boys made their way in early life by exploiting their athletic ability. The family attended parochial grade and high schools in Denver. Frank attended Sacred Heart Grade School and St. Francis Grade and High School.

For his senior year in high school Frank transferred to Cathedral High School to play football because St. Francis had no football team at the time. Frank's older brothers were attending college on the basis of their athletic abilities and so Frank needed some football experience. His oldest brother was a standout at the School of Mines, attracting national attention to the school. Frank also played baseball. During the summer he played semipro ball. The games were well attended and the players made some money to live on.



The summer after he graduated from high school, he was playing ball at the stadium at 23rd and Welton. During one game late in the season, he suffered a compound fracture of his ankle when he slid into second base. He had been hoping to go to college on an athletic scholarship but things looked bleak after the fracture. He remembers the tibia sticking through his skin. He was treated with external fixation and has very little residual from the break. There was a black team called the White Elephants playing in his league. One evening shortly after his accident, some black kids showed up at his front door. His mother didn't know what to think. The players said they know he needed money to go to college so they were going to put on an exhibition double header on Labor Day and donate any proceeds to him for school. They gave him over $700.

Frank attended the University of Colorado, graduating in 1934. As a football player, he was eligible for part-time jobs around campus. No scholarships were given in those days. For a couple of years he hashed at a sorority house. When CU had a good football game, he was treated royally, but when he had a bad game he had to suffer a lot of abuse. In those days students had three years of football eligibility and four years of baseball eligibility.

After he entered medical school he played one more year of baseball for CU in Boulder. He would work out during the week in Denver and drive to Boulder for games. He was surprised that the dean of the medical school approved such a plan. He is still active in the CU Buff Club. We talked a little about the difference between the college athletic programs of his day and today. He thinks he probably had more fun than most athletes of today.

He graduated from CU medical school in 1938 and took a year and a half of house officer experience at the county hospital. He then spent six months studying gastroenterology at the University of Chicago. Frank returned to Denver in 1940 where he became a medical assistant at the medical school and shared an office in the old Majestic Building with Irv Hines. He became the first civilian physician to be drafted into World War II in Denver. He was part of the 29th General Army Hospital in the South Pacific staffed by faculty from the University of Colorado. He practiced gastroenterology and saw a lot of parasitic G.I. diseases, hepatitis and peptic ulcers.

He returned to Denver in 1946, a little later than many of his colleagues. Ken Sawyer had been his roommate in the South Pacific and was already in active practice when he returned. Ken helped him get started again. They took offices at 1820 Gilpin. In 1948 young George Curfman returned to Denver after some pathology training at Johns Hopkins Hospital. They formed a loose association and in 1950 Bob Hayes also joined them.

In 1952 they moved to the big gray building on the corner of 18th and Williams which was owned by N. Paul Isbell. They called themselves the Greystone Medical Group. The group expanded to include Phil Clarke and Grey Davis and in a few years totaled ten people. Group practice was unusual at this time and created some hostility and misgivings by other physicians in the area. The group talked about expanding to other specialities and about this time Bernie Daniels and Bill Coppinger who also had offices in the Greystone Building proposed an association. The group next started talking about building their own building but they really did not have the finances to undertake such a project.

The Foundation's major effort is the treatment of the elderly.

Helen Bonfils was a patient of Frank's and he discussed the group's plans with her hoping she might lend them some money. She did better than that. She owned the property where the clinic is now and built them the building and leased it to the group at a nominal fee. Thus the Denver Clinic was formed and they moved into their new facility in 1957. A second building was added in 1962 and an annex was built in Aurora in 1972. The group gradually overcame the professional antagonism against it by employing many of the prominent practitioners in town as consultants.

At the same time the Denver Clinic group was in its formative stage, Frank established the Medical Research Foundation. The idea for the foundation came from one of his patients, Bill Regent, who was a district supervisor for the Sun Oil Company. Medical insurance was not a common benefit and Mr. Regent would pick up the major medical bills of his employees. It was decided that a foundation was a good method of channeling funds for such an endeavor. Unfortunately, Mr. Regent died before the foundation was endowed. However, the foundation continues to exist and serves a purpose for the donation and distribution of funds. The major effort of the foundation now is the service, research and treatment of the elderly.

The foundation is one of the supporters of the senior programs that are housed at the old Emerson School. There is a clinic at the school called the Johnson Clinic (named for the Arthur Johnson Foundation which supports it) which is staffed by a nurse practitioner and volunteer physicians on a rotation basis. Frank supervises this clinic.

Frank was married to one of the O'Meara girls (the first Ford dealer in Denver) in 1940. They raised four children. Their oldest boy died suddenly in his forties. Their youngest boy, Tom, is a surgeon in the Air Force stationed in Japan. One daughter is a nurse, a missionary in Peru. Another daughter is an administrative assistant to the National Parenteral and Enteral Alimentation Association.

Frank has continued his athletic endeavors and interests throughout his life. He still plays squash two to three times a week and plays golf at least once a week. He plays to a 13 handicap.

A plaque above his desk states: "Avenge yourself, live to be a burden to your children." I couldn't bring myself to ask him if that was one of the remaining goals in his life.

The Year in Medicine: 1983

A summary of the year's biggest medical news stories from the American Medical News and Journal of the American Medical Association, James Stacey, Science News Editor.

The emphasis in 1983 was on information. The year in fact might have marked an historic shift away from public fascination with pure advances in medical technology to more sober reassessments of the impact of technology on human life, according to James H. Sammons, M.D., executive vice president of the American Medical Association.

Certainly, that was the effect of the year's biggest story: the implantation of an artificial heart that sustained the life of Barney Clark for 112 days. Shortly after the death of the 61-year-old dentist in March, Stephen Kent Clark, M.D., his son, observed that the operation was "not worth it" in terms of useful prolongation of life or added quality of life. Dr. Clark told *American Medical News* in April that his father "never really thought the artificial heart would work for him. All he expected to do was make a contribution to medical research." At the same time, the son commended both the University of Utah medical team and the artificial heart.

Less dramatic but no less humanly appealing were stories concerning liver transplants for youngsters, such as 10-month-old Jamie Fiske, the Massachusetts child who successfully received a transplanted liver at the University of Minnesota. In the wake of her experience, public attention focused on the plight of several other children, not all of whom were able to accept transplanted organs. With costs for the procedure approaching $175,000, some physicians, including Neal A. Vanselow, M.D., of Minnesota, noted the clash between costly advances in medical science and concerns for holding down the costs of medical care. In an April *JAMA* medical news story, Dr. Vanselow pointed out that one transplant operation might pay for as many as 175,000 doses of vaccine and suggested that the medical profession alone could not resolve the conflict between the costs of technology applied to one individual and the more general medical needs

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of society.

The conflict between technology and society moved into the legal arena with several actions related to the "Baby Doe" regulation promulgated by the federal government. At issue was the question of decision-making about medical treatment for infants born with life-threatening birth defects. The government has insisted that medical treatment be applied essentially without regard to the quality of the life prolonged, an insistence that many consider an unwarranted intrusion into the private lives of families.

AMA Executive Vice President Sammons says, "The AMA believes the proposed rule is an inappropriate intrusion by the federal government into an area best left to families, physicians and community leaders. The federal government can contribute significantly to those having to make these difficult decisions if, instead, it encourages dissemination of reliable information concerning up-to-date methods for treating severely deformed newborns and if it helps to improve support systems and other community resources that could assist parents in caring for handicapped infants," he adds.

Information was at the core of other major medical stories during 1983, one of the more alarming of which was the unfolding drama relating to the acquired immune deficiency syndrome (AIDS). At year's beginning, AIDS appeared to affect only male homosexuals, IV drug abusers, Haitians and hemophiliacs. Then in May came a report from *JAMA* that several children in Newark, New Jersey had been stricken with an AIDS-like immune deficiency. All were living in high-risk households and researcher James Oleske, M.D., M.P.H., said the experience suggests that disease transmission may not be restricted to sexual contact, drug abuse or exposure to blood products.

Other reports suggested that female partners of bisexual males also were contracting the disease. Researcher Arye Rubinstein, M.D., hypothesized in *JAMA* that AIDS can be transmitted to fetuses in the mother's womb.

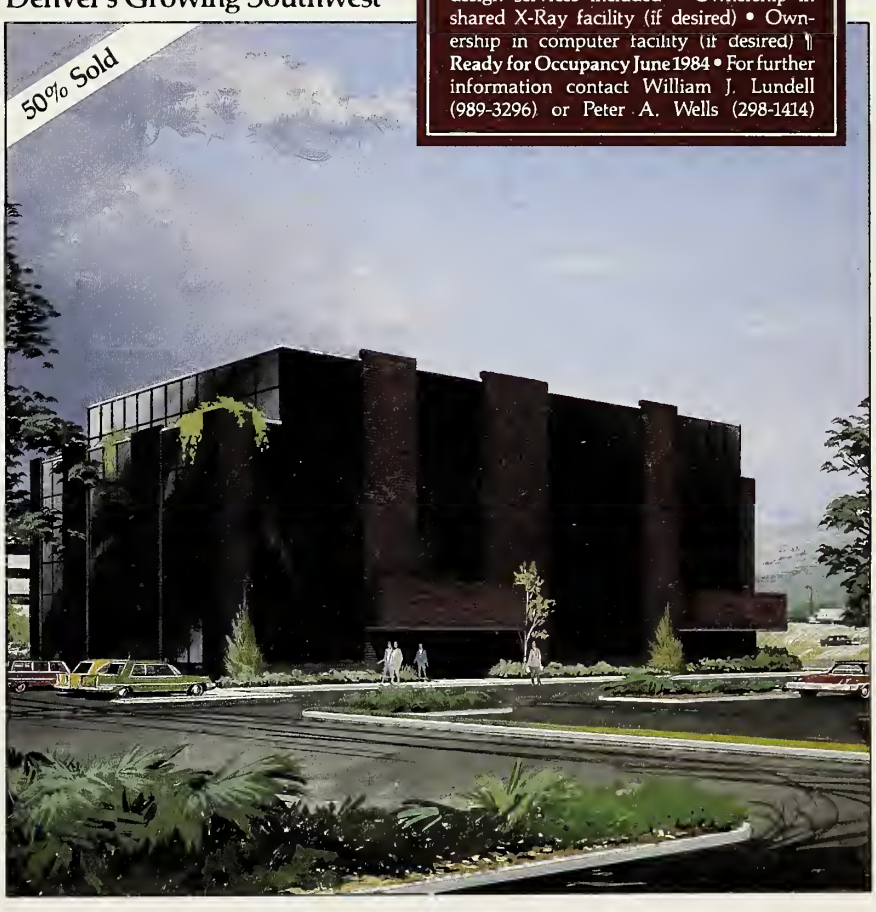
By year's end, the total number of AIDS cases reported to the Centers for Disease Control in Atlanta had passed 2,800 and reports from Europe noted that 267 cases had been reported there. While spread of the syndrome has markings of an epidemic, it appears that life-style changes, particularly among male homosexuals, may be limiting disease transmission. Also at year's end, Dr. Oleske told *American Medical News* that "AIDS is a disease of very low infectivity and that by being thrown into the research breach we have learned more in the last three years about the immune system and cancer than we probably would have learned in 20 years."

Medical information of a decidedly positive nature came in March with a CDC report in *JAMA* clearing use of oral contraceptives from risks associated with certain cancers. The large-scale study showed no relation between the use of the pill and the incidence of breast cancer. It additionally showed that use of oral contraceptives actually lowered the incidence of endometrial and ovarian cancer. Evidence suggested that

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2,000 endometrial and 1,700 ovarian cancer cases were averted each year as a result of oral contraceptive use. That positive news was modified somewhat by a British report in October that suggested that women who use the pill have a 75 percent greater risk of developing cervical cancer.

Advances in human fertility research continued to be made during 1983. Greater success was seen in embryo transfers after fertilization both in vitro and in vivo. An additional advance was reported in an October *JAMA* when Gary D. Hodgen, Ph.D., announced that successful transfer of an embryo to a primate lacking ovarian function. The transfer depended upon hormone replacement therapy during early embryonic development, described as a difficult problem brilliantly solved, according to in vitro fertilization pioneer Howard W. Jones, Jr., M.D.

The relationship between dietary salt and blood pressure continued to be probed by researchers during the year. In July, scientists from the Netherlands published a report in *JAMA* that offered the first experimental evidence in humans that a lower salt diet leads to lower blood pressure. The researchers studied 476 infants during the first six months of life and showed that those on a lower dietary salt intake had statistically lower systolic blood pressure than those on a normal sodium diet.

One of the more striking pieces of medical news during the year came in July, when *JAMA* published an article that it had roundly rejected 84 years before. Titled "The Gynecologic Consideration of the Sexual Act," the paper by Denslow Lewis, M.D., was greeted with general hostility when first presented to the AMA at its 50th annual meeting in 1899. At that time, such papers were routinely published by the journal, but the editor and AMA Board of Trustees at that time refused to do so on the grounds of propriety. William H. Masters, M.D., of Masters & Johnson Institute, hailed the paper and speculated that its publication in 1899 might have beneficially altered the study of human sexuality. It was published in July as a landmark paper

Wonderland

(Continued from p. 45)

offering the contract to determine its credibility and fiscal soundness.

It is highly likely that contracting arrangements will continue to grow and proliferate, and physicians would be well-advised to learn to analyze a physician participation contract. Several medical societies around the country have developed written guidelines for use by their membership in reviewing contracts. The California Medical Association has prepared a framework and specific guidelines have also been developed by the Hennepin County Medical Society. At minimum, physicians should review the following areas before entering into any contract:

1. What are the PPO's claims payment responsibilities?
2. What are the details of the utilization control plan?
3. What are the provider's obligations to accept PPO patients?
4. Are the parties' termination rights spelled out?
5. What are the limitations or controls on referrals?
6. Are there malpractice and/or liability insurance requirements?
7. Is the provider required to indemnify the other party to the contract?
8. What mechanism(s) exist for dispute resolution?

In addition, physicians would be well-advised to review such contracts with their individual legal counsel if there is any area or portion of the contract that is vague or unclear.

In summary, just as Alice found a bewildering new world where all the familiar rules had ceased to operate, physicians are likely to find the rapidly changing medical reimbursement system to be a source of concern and confusion. As developments proceed in this arena, the Colorado Medical Society will attempt to keep our members informed of the potential effects upon their practices.

Drug Therapy

(Continued from p. 50)

hepatic or renal impairment, hypothyroidism, prostatic hypertrophy, Addison's disease and in elderly patients.

H. Adverse Effects

1. Constipation is common and usually responds well to daily lactulose and enemas prn.

2. Agitation, restlessness, nightmares, tremors, hallucinations and diaphoresis have been reported and respond to dose adjustment (Ensworth, 1979).

3. Local phlebitis has been reported.

4. Postoperative respiratory depression is more frequent in patients receiving continuous morphine infusions than in those receiving extradural or intercostal nerve block (Catling et al, 1980).

Conclusion:

Continuous intravenous morphine infusions may be preferable to intermittent parenteral dosing in terminally ill chronic pain patients. Continuous subcutaneous infusion is an attractive alternative in select patients who can be monitored adequately at home.

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March

1 **Neuropsychiatric Grand Rounds** — Colorado State Hospital, Conference Room "A", Pueblo, Colorado. Time: 1–3 p.m. APA approved course for Category 1 credit. For information contact James H. Scully, MD, 1600 W. 24th Street, Pueblo, Colorado. Phone: (303) 543-1170.

1-2 **The Microcomputer Jungle: Impact on Health Care** — University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. Credit: 15 hours AMA, CNE, PT, SW, Dietitian pending; 13.5 hours AAFP. Fees: $90.00 for physicians, nurses and therapists and $45.00 for students and residents. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

3-10 **9th Annual Family Practice Conference** — Marriott's Mark Resort, Vail, Colorado. 22 hours credit: AMA Category 1, AAFP Prescribed and CNA. Contact the Beth Israel Conference Program, P.O. Box 11338, Denver, Colorado 80211. Phone: (303) 629-5333 or toll free (800) 525-5810.

3-10 **7th Annual Cancer Treatment Conference** — Lion Square Lodge, Vail, Colorado. 22 hours credit: AMA Category 1, AAFP Prescribed and CNA. Contact the Beth Israel Conference Program, P.O. Box 11338, Denver, Colorado 80211. Phone: (303) 629-5333 or toll free (800) 525-5810.

4-9 **5th Annual Mammoth Mountain Emergency Medicine Ski Conference** — Mammoth Lakes, California. Fees: physicians, $325.00; nurses, $190.00; physicians in training, $225.00. 20 hours of credit AMA Category 1, AAFP elective, and Board of Registered Nurses contact. For information contact Daniel L. Abbott, MD, Program Director, Medical Conferences, Inc., P.O. Box 52-B, Newport Beach, California 92662. Phone: (714) 650-4156.

5-6 **Annual Cardiology Postgraduate Symposium** — University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. Credit includes AMA Category 1, AAFP and CNE. Fees: physicians, $300.00; nurses, $85.00. Contact the Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

7-9 **34th Annual Course for Physicians in Family Practice** — Mount Zion Hospital and Medical Center, San Francisco, California. Contact Martin Schimerlik, Office of Continuing Education, Mount Zion Hospital and Medical Center, P.O. Box 7921, San Francisco, California 94120. (415) 567-6600, ext. 2404.

9-11 **Cardiovascular Disease:** Non-invasive Diagnostic Methods (Stress and Holter ECG) and Cardiac Rehabilitation — Doubletree Inn, Denver, Colorado. Contact International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. Phone: (303) 790-8445 or (800) 525-8651.

10-17 **9th Annual General Surgery Conference** — Marriott's Mark Resort, Vail, Colorado. Tuition: $335.00 for practicing physicians $225.0 for residents, nurses and other health professionals. 22 hours credit: AMA Category 1, AAFP Prescribed and CNA. Contact the Beth Israel Conference Program, P.O. Box 11338, Denver, Colorado 80211. Phone: (303) 629-5333 or toll free (800) 525-5810.

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10-17 **5th Annual Clinical Brain Conference** — Kiandra Lodge, Vail, Colorado. Tuition: $335.00 for practicing physicians $225.0 for residents, nurses and other health professionals. 22 hours credit: AMA Category 1, AAFP Prescribed and CNA. Contact the Beth Israel Conference Program, P.O. Box 11338, Denver, Colorado 80211. Phone: (303) 629-5333 or toll free (800) 525-5810.

12-16 **8th Annual Vascular Surgery Symposium** — Givin Institute of Pathobiology, Aspen, Colorado. 25 hours AMA Category 1 credit. Contact the Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East 9th Ave., Box C-295, Denver, Colorado 80262. (303) 394-5241.

15 **Sports Medicine: Rehabilitation of the Injured Athlete** — Kansas City, Kansas; Westin-Crown Center, Kansas City, Missouri. Credit is pending. Fee: $75.00 for health professionals and $30.00 for students and residents. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

15-16 **Advanced Trauma Life Support** — Kansas City, Kansas. 16 hours credit AMA Category 1 and 15 hours AAFP. Fee: $350.00. Contact Jody Scott, Department of Surgery, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-6124.

17-24 **9th Annual Internal Medicine Conference** — Marriott's Mark Resort, Vail, Colorado. 22 hours credit AMA Category 1, AAFP prescribed and CNA. Tuition: $335.00 for practicing physicians and $225.00 for residents, nurses and other health professionals. Contact the Beth Israel Conference Program, P.O. Box 11338, Denver, Colorado 80211. Phone: (303) 629-5333 or toll free (800) 525-5810.

21 **Hepatitis and Chronic Active Liver Disease** — Alamosa, Colorado. Speaker: Jeffrey Huston, MD. 2 hours credit AMA Category 1 and AAFP prescribed. Contact Martin Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, Colorado 80203.

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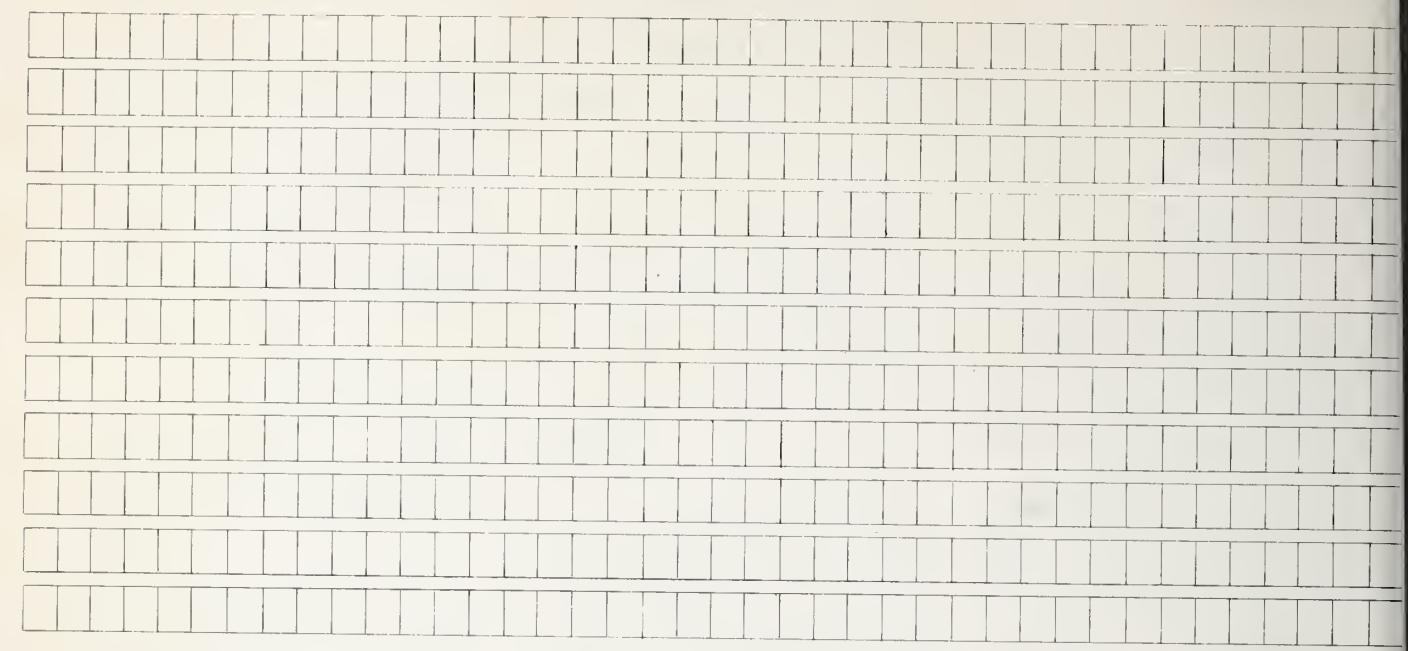


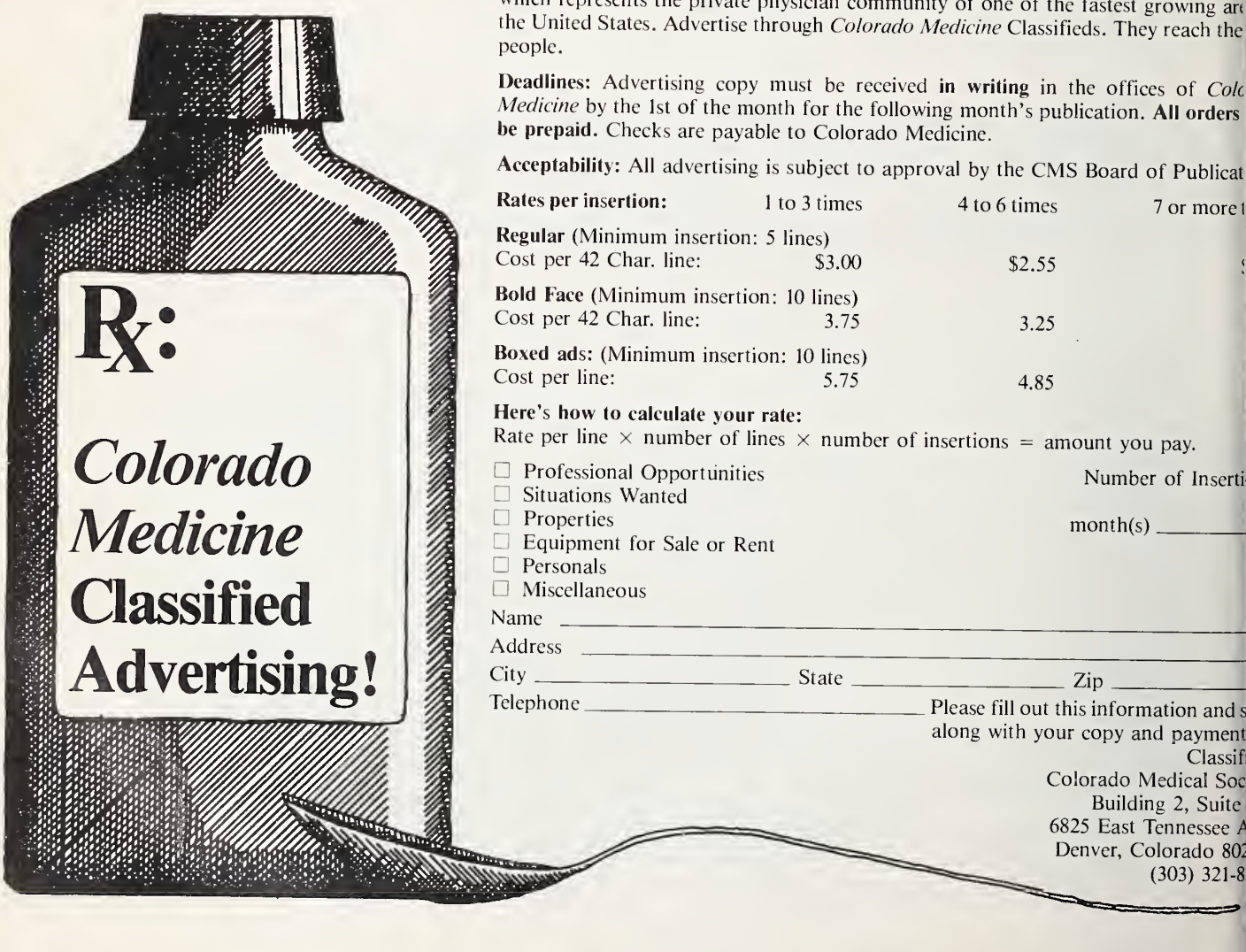
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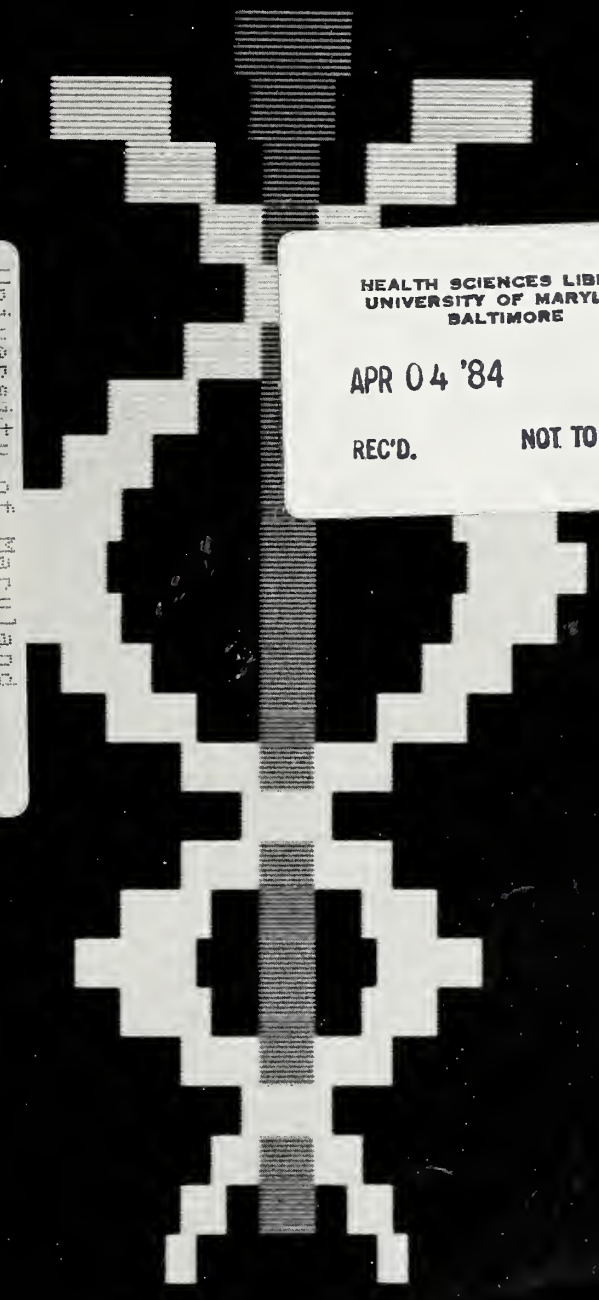
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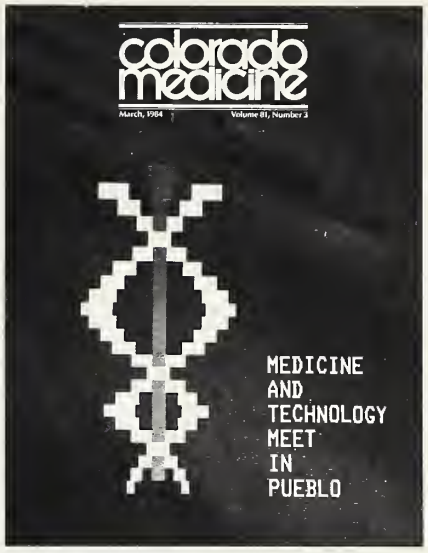
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This Month's Cover

When you think of Pueblo, high technology probably isn't the first thing to come to mind. However, Pueblo is changing and so is its image. A large contributor to the changing face of Pueblo is the University of Southern Colorado. In April, USC and the Pueblo County Medical Society are sponsoring a two-day conference on the technological future of medicine. The conference has attracted many noted speakers and participants. For details on this important seminar, see p. 75.

Colorado has one of the worst low birth weight rates in the United States. What are some of the causes and what can be done to solve this problem? The article by Robert S. McCurdy, MD, begins on p. 81.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

CMS Communications

Communication is a vital element in our existence. It is the cement that binds day-to-day activities, programs and plans. Your Colorado Medical Society has recognized the importance of communications and has placed it high on its priority list.

The CMS Department of Communications has become the focal point of this effort. It serves you and your patients well. The publications from this department include the *Physicians' Directory, Colorado Medicine,* the official journal of CMS and the *CM Scanner.* Other activities include staffing and advising the Public Information Committee, establishing the Perkin Awards for outstanding journalism and, not least of these, establishing and maintaining healthy relationships with the media. The latter effort, requested by many of you, has produced outstanding objective reporting by the media such as recent interviews with Denver radio stations and the Associated Press and articles on stimulant drug restrictions, DRGs, the new director of the Department of Health and Hospitals and the impaired physicians.

CMS is encouraging this good climate of relations by fully cooperating with representatives of the media. One result of this cooperating has been direct communication between reporters and CMS officers almost weekly for CMS input on medical issues. CMS officers have also agreed to interviews on current medical topics when they make visits to component societies. The following letter from myself to Bill Symons, medical writer on the *Denver Post* is one example of our efforts for positive action in this area.

Dear Bill,

I greatly enjoyed talking to you on the 30th of December and learning of your forthcoming article on Prospective Payment (DRGs) for hospitals under Medicare. Your recent article on urinary tract artificial sphincters was outstanding.

Prospective payment will very likely soon involve physicians and may become an all-payer system in Colorado. If and when it does, the cost shifting that has paid for hospital services unable to support themselves (education of future health care providers as well as care to the indigent, etc.) will be radically curtailed or will cease. This will create new and rather severe problems for health care delivery for Colorado. In anticipation of these problems, the Colorado Medical Society has created a medical staff section for each hospital medical staff to work in close cooperation with their hospital, attempting to solve these new and difficult problems.

> CMS has established healthy relationships with the media.

Cost containment efforts, as exemplified by prospective payment to hospitals, is only one of the forces causing codification, and even restructuring, of the health care delivery system. It is extremely important and has extensive ramifications, but the most significant issue is, "What will be the final product?" What form will our health care delivery system take when all the present forces have worked their will upon it? These are the concerns of the Colorado Medical Society and these concerns have been forwarded to the Governor and the Colorado Health Forum (a volunteer group of civic, government, medical insurance and legal experts who address health problems). The "final product" is the essence with which the public of Colorado should be concerned. All citizens should be working toward a system that, in its final form, blends quality, access and reasonable cost. . .

Your Colorado Medical Society will continue to serve you and your patients through the many and diverse modes of communication.

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Economic Issues Facing Colorado Physicians

guest editorial



Donald Parsons, MD, Chairman, CMS Council on Socio-Economics

Sweeping changes in health care delivery and financing have taken place in response to the near-panic over burgeoning health care costs. The CMS Council on Socio-Economics has focused much of its attention on these events. Many concerned physicians, insurance specialists and others have appeared before recent council meetings to provide information, analysis and counsel on health care economic issues. They have included Gary VanderArk, MD, Tom Balkany, MD, Edgar Smith, Joe Turnbow, MD, Evelyn Choury of Blue Cross/Blue Shield and representatives of the Colorado Medicaid program, of the Region VIII Health and Human Services office, the Colorado Task Force on the Medically Indigent and the Colorado Health Forum.

One fascinating recent development has been the growth of the preferred provider organization (PPO). The development of PPOs in Colorado has resulted from an initiative by union trusts. Thus emerged Mountain Medical Affiliates, the Sloans Lake Group, St. Joseph's Organization of Independent Physicians and others. In California, such entities can competitively bid for health care delivery contracts. These organizations, along with traditional alternative delivery systems such as HMOs and IPAs are now a focus of the government as it seeks to flesh out the promise that physicians will be paid on a DRG basis by 1985.

Many PPOs are brainchildren of hospital corporations. As such, they may make physicians dependent on hospitals and their contracting authority. Are physicians prepared, in the competitive environment promised by GMENAC, to become hospital-dependent, or hospital-employed, to survive in an uncertain world?

Other PPOs are controlled by physicians. The Arapahoe IPA and the Denver Medical Practice Association are examples. These organizations plan to contract for professional services with employers, union trusts, small employer trusts and third party payers. They then will contract with hospitals for assured access to facilities. Since the principal contract is to exist between the purchaser and the physician corporation, will this mean that the physicians are in control *vis a vis* the hospital? Is there an intermediate arrangement in which physicians and hospitals can share control?

What are the tradeoffs for assured patient population? If this group of patients constitute only five percent of your practice, a 10 to 25 percent discount is no major loss. What if this group constitutes 90 percent of your practice? Are you willing to take a 10 to 25 percent pay cut? What happens if the PPO down the block offers a 30 percent discount?

Safeco, CIGNA and other large health care purchasers have set up organizations similar to PPOs. Some physicians were willing to accept a discounted fee scale for an assured patient population, rapid payment of billed charges, no bad debt or collection nuisances, etc. The insurance companies realized, too late in Safeco's experience, that the fee-for-service incentives were too strong. Utilization crept up; what else would you expect? And Safeco went

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broke.

1984 has arrived with "Big Brother" in tow. Along with discounts, physicians have been asked to accept severely stringent utilization controls: preadmission certification, mandatory (or "incentive") second opinion programs, concurrent hospital review and, horrors, retrospective denials. These programs usually are to be conducted by insurance company or purchaser hirelings rather than by peers. How do you feel about working in that kind of environment?

Are there alternatives? Tom Golbert, MD, of the Council on Socio-Economics, feels quite certain that physicians will be left without recourse unless they aggregate with statutory recognition for rights of negotiation, arbitration and bargaining — that is, establish unions, which are defined and protected by a large body of existing law. Others suggest that incentives such as capitation prepayment may offer physicians more professional freedom than fee-for-service reimbursement encumbered by strict regulation and review.

The federal government hasn't decided how to fund the physician DRG. Should the government pay the hospitals the full amount for a DRG and pay the physicians through the hospital? Or should it pay individual physicians the full amount and have them pass on a portion to the hospital? Another option is to fund such care through one of the new alternative delivery systems. These questions are open, but they will be answered by the end of this decade. And whatever works for Medicare will serve the commercial insurors, self-insured employers and union trusts equally well.

Do we as physicians see these issues and questions as matters of concern to us all, or do we want to abandon our collective societies to seek our best options individually? Now is the time for you to choose. The major question is who will control the practice of medicine. If you are concerned or have answers, come to the next Council on Socio-Economics meeting, which are free dinner meetings open to all members. Call Melba Pascal at 321-8590 to make a reservation.

auxiliary report



Bunkie Inkret, President,
Colorado Medical Society Auxiliary

To Be or Not to Belong

Each spring the county auxiliaries plan the upcoming year and high on the list of priorities is membership. Through active, participating members, manpower is derived to accomplish the goals established. Dues of all members help fund the programs and projects planned.

It is also at this time of year I ask myself: "Why did I join the auxiliary and why do I maintain my annual membership?"

Is it because it is exclusive? Did you know there can be only about 7,000 auxilians in Colorado? To qualify for membership a person must be the spouse of a physician or medical student who meets Colorado Medical Society membership qualifications, or the widow or widower of a physician who qualified for membership at time of death, provided that person has not remarried outside the profession.

Is it because of prestige? We are an auxiliary to an organization whose members are of a profession proud of its devotion to the highest ethics and caring for the sick! To Americans, doctors are special; they are expected to have a special streak of humanitarianism and high ideals awarded to no other group.

Is it the challenge? It is challenging to build energy on energy, to build success, using the experience and foundations of the past as new programs are developed.

Is it the education? Many of the advantages of the auxiliary are the resources that are available from the AMA Auxiliary to any member — and these resources cover numerous subjects. Programs presented at local levels also provide information related to medical needs in the community and prepare volunteers to identify and find solutions.

Is it the experience? With the wide variety of current programs, the experience to be gained is immeasurable. A member can gain a wealth of experience in health education, legislation and the political arena, fundraising, meeting planning, leadership, communication skills and much more.

Is it the benefits? Did you know the AMA Auxiliary maintains a project bank and catalog available for use to organizations on request?

> It is satisfying to give, to help and to serve my fellow man.

There is also a "people bank" that provides speakers and educators for your use. Did you know there are publications put out at county, state and national levels that provide members with current and pertinent information and news?

Is it because of the camaraderie? A member of the CMS Auxiliary will make new acquaintances and friendships through participating in CMSA.

Yes! Yes, I joined the auxiliary for all of the above and I have maintained that membership for many more reasons. Among the most important is that it is satisfying (undoubtedly from my nursing background) to give, to help and to serve my fellow man. When I expend energy to support my spouse's profession it makes me feel good. It is rewarding for me to know I have made a positive effort to help the practice of medicine in the future and that the effort will affect the medical care of my children, their families and all of society.

May I say the auxiliary appreciates all you physicians who have shared your auxilian spouse with us and hope that she/he will continue as a member. May I also ask you physicians whose spouse is not an auxilian to extend an invitation for us to please join us? We can do more together.

Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation group for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit the patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

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Patrick G. Moran, MD, Chairman, Council on Professional Education
David Haggerty, Director, Division of Professional Services

Summary of CME Requirements

Editor's Note: The following article, by Barbara J. Dwyer, is reprinted with permission from the CME Bulletin, Winter, 1984. This quarterly publication features a comprehensive listing of CME activities around the country, along with excellent articles and features. To subscribe (4 issues, $15) contact: **American Medical Reports, P.O. Box 77552, San Francisco, CA 94107. (415) 541-0670**

1984 CME Requirements for Primary Care Physicians

The varying CME requirements for primary care physicians often appear baffling. Indeed, physicians in many cases face requirements from their specialty association, medical boards, states, and even hospitals. Fortunately, most of these regulations overlap, and — armed with a simple rule of thumb and few brief explanations — you'll probably be assured of safely meeting your requirements. First of all, the rule of thumb: Remember, if you receive an average of 50 credits per year, the majority of which are Category I or Prescribed, you'll probably meet most of your requirements.

State Licensure Requirements

The following states have regulations that require you to obtain CME credit in order to reregister your license to practice medicine: Alaska, Arizona, Arkansas, California, Hawaii, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, Nevada, New Hampshire, New Mexico, Ohio, Pennsylvania, Rhode Island, Utah, Washington, and Wisconsin, as well as the territory of Puerto Rico.

If you live in one of the following states that has implemented these regulations, you're required to submit formal proof of CME in order to renew your license: Arizona, California, Hawaii, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Mexico, Ohio, Pennsylvania, Rhode Island, Utah, Washington, Wisconsin.

Requirements for American Medical Association's Physician's Recognition Award

If you're an AMA member, you're not required to report CME credit, and therefore the Physician's Recognition Award (PRA) is a voluntary program.

> Call CMS if you have specific questions on CME requirements.

However, the PRA does satisfy the relicensing requirements for Arizona, California, Hawaii, Kansas, Massachusetts, New Hampshire, New Mexico, Pennsylvania, Vermont, and Washington. To receive the PRA, you'll need to earn a total of 500 credit hours over a three-year period. Of these, a minimum of 60 credit hours must be in Category I. The credit classifications and limitations for the PRA are as follows:

Category I: Supervised CME activities with accredited sponsorship: While the minimum requirement is 60 credits, you may apply as many Category I credits as you desire toward your overall requirement.

Category 2: CME activities with non-accredited sponsorship: No more than 45 hours of these credits can be applied toward your educational requirement.

Category 3: Medical teaching: No more than 45 hours can be applied toward your overall requirement.

Category 4: Papers, publications, books, and exhibits: No more than 40 hours of these credits can be applied toward your educational requirement.

Category 5: Non-supervised CME: No more than a total of 45 hours of these credits can be applied toward your overall requirement, and no more than 22 hours in any one subcategory can be applied as Category 5 credit. 5(a) Self-instruction 5(b) Consultation 5(c) Patient care review 5(d) Self-assessment

Category 6: Other meritorious learning experiences: No more than a total of 45 such hours can be applied toward your overall requirement.

If you meet the requirements for other CME programs, such as those sponsored by the American Academy of Family Physicians (AAFP) or the American College of Emergency Physicians (ACEP), it's likely you'll also fulfill the requirements for the AMA/PRA.

Requirements for Emergency Physicians

American College of Emergency Physicians members: If you're a

member of ACEP, you'll need to earn 150 ACEP-approved credit hours over a 3-year period to maintain your membership in good standing. Credit hour category distributions are the same as AMA/PRA; that is, a minimum of 60 hours must be in Category I, and the remainder may be elective, with limits in each category as indicated for the PRA. However, ACEP does not recognize the PRA's category 6, "meritorious learning experiences."

American Board of Emergency Medicine diplomates: To be eligible for certification by ABEM, you're required to have 50 hours of CME credit in any category for each year you've been in practice. Recertification is required after 10 years, and ABEM is currently drawing up CME criteria for this.

Requirements for Family Practice Physicians

American Academy of Family Practice members: To remain an AAFP member in good standing, you'll be required to earn 150 AAFP-approved credit hours over a three-year period. Of these, at least 75 must be from prescribed (supervised) sources and the remainder from personal interest or elective sources.

American Board of Family Practice diplomates: If you completed your residency over 3 years ago, you'll need 50 hours of Category I credit for each year of practice to become certified by the ABFP. The board requires recertification of its diplomates every six years, and the CME requirements are identical to those approved for reelection to membership in AAFP.

Requirements for Osteopathic Physicians

American Osteopathic Association members: To remain a member of the AOA in good standing, you'll need 150 hours of credit every 3 years. Of these, a minimum of 60 credit hours must be in Category I.

Category 1: Must be from osteopathic sources. While the minimum requirement is 60 credits, you may apply as many Category I credits as you desire to your overall requirement. Category I activities are formal educational programs approved by the AOA, and these include: educational programs sponsored by osteopathic institutions and organizations; preparation and writing of scientific papers and publications; osteopathic medical teaching; conducting osteopathic hospital inspections for accreditation; attendance at AOA-approved hospital education; and other osteopathic CME activities that are approved by the Committee on Continuing Medical Education.

Category 2: Allopathic sources: No more than 90 hours of these credits can be applied toward your overall requirements. 2(a) Attending hospital committee meetings at allopathic hospitals 2(b) Home study 2(c) Preparation and presentation of scientific exhibits 2(d) Formal programs sponsored by allopathic institutions 2(e) All other programs and CME approved by the Committee on Continuing Medical Education.

The AOA grants certification to osteopathic physicians, and no CME is required for election to its various boards.

Requirements for Internists

American College of Physician members: If you're a member of ACP, you need not report your continuing medical education to maintain your membership.

American Board of Internal Medicine diplomates: ABIM does not require CME prerequisites for certification and has no continuing education requirements for recertification.

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Conference on the Geriatric Patient

The Western Colorado Consortium on Aging Services Education and the Medical Care and Research Foundation (MCRF) are sponsoring a conference entitled "The Geriatric Patient — Old Problems, New Approaches," March 12 and 13, 1984, Vail, Colorado. The conference agenda will address the specific interests and concerns of western Colorado health care practitioners surrounding the care of the older patient. Call 831-0264 for information.

Don't Forget . . . Upcoming Conomikes Practice Management Workshops

"Establishing Yourself in Medical Practice" for physicians just entering practice. Cherry Creek Inn, Denver, April 5–6, 1984.

"Six Medical Practice Management Workshops" for physicians and medical office personnel (a repeat of the same popular programs offered in November, 1983). Cherry Creek Inn, Denver, May 15–18, 1984.

Call the Colorado Medical Society, Division of Professional Services, (303) 321-8590, for information.

Kenneth A. Kahn, MD, Associate Medical Director
Andrea C. Mitchell, Supervisor, Hospital Review Program

Review under the Prospective Payment System for Medicare

On October 1, 1983 hospitals across the country began phasing in to a prospective reimbursement system for their Medicare patients. The cornerstone for calculating reimbursement under this system is the Diagnosis Related Group (DRG). As the PSRO for the state of Colorado, the Foundation has begun to modify a number of review functions to be consistent with the new program and the Foundation's current Medicare PSRO contract. The purpose of this article is to describe the Foundation's review functions under this new reimbursement approach.

It is important to recognize that the new system will utilize Peer Review Organizations rather than PSROs. The Foundation intends to win the PRO contract for the state of Colorado. Whether or not the Foundation serves as the PRO the reader can assume that the fundamentals of review under the system as described below will hold true.

DRG-Based Reimbursement

DRG-based reimbursement is being implemented as a means of controlling the rise in health care costs to the federal government under the Medicare program. This new reimbursement system was implemented to change the financial motivations for treatment on the part of the hospital and its medical staff. Although physicians are not directly included in the new payment system, most observers predict their inclusion in the next few years.

Prior to DRG-based reimbursement, hospitals were reimbursed for the care provided to Medicare patients based on the costs of caring for that patient. Under the old reimbursement system if hospital A kept a patient for six days and the patient received 10 different services hospital A would be paid more than hospital B who kept the same patient for three days and performed only five services. In other words, the more services and care the hospital provided the more Medicare would reimburse the hospital. Thus, there was a motivation built in to the reimbursement system for the hospital to provide more care and more services.

DRG-based reimbursment is designed to encourage hospitals to provide only the care that is necessary for the patient's treatment. Under DRG-based reimbursement a patient is classified into one of 470 different DRGs. A hospital is paid for the patient's care based not on the services provided or the length of stay but upon the patient's DRG assignment. Under DRG based reimbursement each DRG has a fixed weight factor. That weight factor and cost data from each hospital are combined mathematically (including factors that reflect local and national variances) to determine a reimbursement for each patient. Thus every hospital may have slightly different reimbursement for patients under a given DRG.

DRG-based reimbursement applies to all hospitals which treat Medicare patients except psychiatric hospitals, pediatric hospitals, long term care hospitals and rehabilitation hospitals. "Distinct part units" of general acute care hospitals can also apply for exemption if their primary purpose is to provide psychiatric care or rehabilitation. "Swing beds" are also not under the DRG based reimbursement system.

Hospitals are being phased in to DRG reimbursement in conjunction with the start of their fiscal years. As of December 1, 1983 there were three hospitals under DRG-based reimbursement in Colorado. By January 1, 1984 there will be a total of 57 hospitals under DRG based reimbursement and all non-exempt hospital will be in the system by October of 1984.

Review by The Colorado Foundation for Medical Care

Since 1974, the Colorado Foundation for Medical Care has had a PSRO contract with Medicare which defines the Foundation's PSRO review responsibilities. Under the PSRO contract the role of the Foundation has been to assure Medicare that the services delivered to patients were medically necessary and delivered in the appropriate setting. Accordingly, the Foundation traditionally focused its review activities on the patient's need for admission

Rehabilitation Groups of the American Cancer Society

Laryngectomee Association

With the approval of the attending physician, trained volunteers who have had laryngectomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support for learning to speak again. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

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to the hospital and the patient's continued need for hospitalization.

Because hospital motivations under DRG-based reimbursement are different, the review activities specified by the Foundation's PSRO contract are being modified. The old review system concentrated on eliminating unnecessary days of care and unnecessary services because the hospital had no financial incentives to limit length of stay or the number and type of services provided. Under DRG reimbursement the incentive is to shorten stays, diminish services, and perhaps concentrate on the less severely ill cases. Obviously this could create perverse incentives to good patient admissions and quality care.

General Review Process

The classical PSRO review was essentially performed concurrently, i.e. while a patient was in the hospital. The new review system will be entirely retrospective, i.e. the patient may have been discharged as much as one to two months before the Foundation performs review. A second major difference is relative to the implications of this review. That is, if a determination of inappropriate or unnecessary care is made, retroactive denial of payment to the hospital will result. Thus a patient may be admitted and discharged before the hospital knows that the stay will not be paid for by Medicare.

Specific Review Functions

The following are the specific review functions which will be performed by the Foundation under its Medicare contract, the rationale for each, and a brief description of how physicians will be affected by this review.

Admission Review — Under DRG-based reimbursement, admission review will be the Foundation's most valuable tool. As mentioned earlier, the hospital will be reimbursed based on the patient's DRG regardless of the length of time the patient is in the hospital or the number and/or cost of the services provided to the patient. It is to the advantage of the hospital to care for patients who will stay a short time and will require few or less costly services. The role of the Foundation in admission review, then, is to assure that patients entering the hospital are sick enough to require hospital level services.

In performing this review the Foundation is continuing to use the Severity of Illness/Intensity of Service screening criteria originally developed by Interqual. The Foundation has been using these criteria for approximately three years and the criteria have developed, through several revisions, into a tool which can be applied easily and quickly by nurse coordinators to screen out the vast majority of cases. When the nurse coordinator cannot determine the admission to be appropriate based on the criteria, the case must be referred to a Foundation physician advisor for a determination of medical necessity.

Under DRG-based reimbursement, physicians may expect to see increasing effort on the part of the hospital to assure that they do not risk retrospective denial of payment due to patients being inappropriately admitted. Many hospitals have or are contemplating preadmission or admission review of patients and many are instituting concurrent review. Physicians should also expect close attention to issues ranging from chart documentation to hospital privileges.

The Foundation intends to win the PRO contract for the state of Colorado.

DRG Validation

The DRG for each Medicare patient is determined by the fiscal intermediary for Medicare which in Colorado is Blue Cross Blue Shield of Colorado. The fiscal intermediary (FI) uses a computer program called the "DRG grouper" to assign a DRG based upon a number of factors concerning the patient and his or her hospitalization. Included among the factors are: principal diagnosis; secondary diagnoses; procedure(s) performed; age and sex of the patient; comorbidity factors; complications; discharge status.

Without an accurate list of diagnoses and procedures it is impossible for the appropriate DRG to be assigned. The Foundation, therefore, is charged with determining whether the diagnoses and procedures that the hospital includes on the bill to the FI for payment are the appropriate diagnoses and procedures based on the patient's reason for admission to the hospital and the services performed as documemted in the medical record.

Physicians should pay particular attention to the principal diagnosis which is defined by Medicare as that diagnosis which, after study, is determined to be the primary reason for the patient's admission to the hospital. This is not necessarily the most severe complication or morbidity. In theory, adverse happenings have been built into the weight assigned to each DRG. A patient, for example, who is admitted to the hospital with abdominal pain which turns out to be appendicitis would have a DRG assigned based on a principal diagnosis of appendicitis. If the same patient fell while hospitalized and fractured a hip which required pinning, the patient's principal diagnosis would still be appendicitis. The hip fracture would be listed as a secondary diagnosis.

The hospital, if there is a question, will be motivated to document the diagnosis which will result in the highest amount of payment. The Foundation's charge is to assure that the diagnostic and procedural information is accurately supplied by the hospital to allow accurate grouping. In this regard we must again emphasize the necessity of attending physicians accurately maintaining medical records. The philosophy that "if it isn't documented, it isn't done" prevails.

Other Reviews

Admission review and validation of diagnoses and procedures will be the principal reviews related to utilization. In addition, the Foundation will be performing a number of reviews which are designed to plug "loopholes" in the DRG reimbursement system as follows:

1. Review of transfers to distinct part units — as mentioned above,

there is the opportunity for hospitals to apply for separate licensure for "distinct part" psychiatric and rehabilitation units which are not covered by DRG reimbursement. In order to get a separate license number for such units the units have to meet a set of requirements which outline the type of patients who can be treated in the unit as well as the qualifications of the staff on the unit.

It is to the advantage of the hospital to transfer to such units patients who may be costly for the hospital to care for under DRG reimbursement. Chronic psychiatric patients who may require extended hospitalization and patients who require extensive rehabilitation could be transferred to the hospital's distinct part unit and their care would then be covered by the old cost based reimbursement system.

The Foundation is mandated, therefore, to review the appropriateness of such transfers, i.e. to assure that patients being transferred to distinct part units are only those patients who are most appropriately treated in such units.

2. Review of "outlier" cases — The opportunity is also presented to hospitals to obtain reimbursement over and above the established DRG rate for those patients whose hospitalizations are extremely lengthy or costly. In order to obtain this additional reimbursement the hospital must request Foundation review of the case before it is billed to the FI. In the case of "day outliers," those patients whose stay is extremely lengthy, the Foundation will review all the days of hospitalization to determine whether the extended stay was justified. In the case of "cost outliers," those patients whose stay is extremely costly to the hospital, the Foundation will review to determine that the costs incurred by the hospital were appropriate, i.e. that the services provided were medically necessary, and that they were ordered by the physician and actually delivered.

It should be noted that a case cannot be both a day and a cost outlier. A cost outlier by definition has not reached the length of stay required to qualify for day outlier status. Furthermore, the reimbursement for both the outliers in general does not hold promise for regaining losses incurred in caring for these types of patients.

3. Procedure review — the final review in the utilization area is procedure review. Under DRG reimbursement a hospital will be able to bill Medicare for an admission for a procedure whether or not the procedure is justified. The Foundation, thus, is required to review at least one procedure to assure that the procedures being done are medically necessary. Because of national as well as local concerns about the insertion of permanent pacemakers, this procedure will be reviewed. Review of permanent pacemaker insertions will, be performed retrospectively at the same time as the admission review and DRG validation reviews. Again, it is important to note that this review may conceivably result in retrospective denial of payment for the entire hospitalization if the necessity for the procedure is not adequately documented in the medical record.

4. Quality Review — the major objections raised to DRG reimbursement by physicians involve fears of poor quality or inadequate care being provided to patients. Because the hospital is no longer reimbursed for services which cost more than the DRG payment provides reimbursement for, it is anticipated that hospitals will be interested in closely monitoring the need for and extent of ancillary treatment and diagnostic services.

The Foundation's review activities are being modified.

The Foundation may implement early in 1984 an ongoing quality review program to assure that patients continue to receive high quality care which is sufficient to meet their acute care needs. During the process of retrospective review the Foundation will be looking at inappropriate care or premature discharge which results in readmission to an acute care hospital within seven days of a previous discharge.

In addition, the Foundation is considering a quality review program to identify those aspects of care which may not be covered by the retrospective review program. It is anticipated, for example, that the patient who is likely to cost the hospital the most and therefore is the most likely to suffer from inadequate care is the chronically ill patient; the elderly patient with multiple problems who may require but is deprived of long hospitalization. The potential exists that minimal care may promote additional complications which may in turn jeopardize the patient's well-being and even cost the system more. Areas currently under consideration for this type of quality review activity on a statewide basis are hospital acquired decubitus ulcers and the administration and hospital monitoring of diuretics and psychotropics.

It is intended that these areas of review will replace the Foundation's Medical Care Evaluation (MCE) and Quality Review Study (QRS) programs. It is anticipated that as data are collected in each hospital for the admission review and DRG validation, that additional data elements will be collected relative to the area of quality review being conducted. As this program develops further information will be provided.

Summary

It must be kept in mind that the only reason for the initiation of the DRG-based reimbursement system is cost control. The system was not designed to improve care, make physicians or hospitals happy, or to make review organizations more efficient or effective. DRG-based reimbursement was implemented to save money. Don't have expectations of the system that cannot be met. There will be unanticipated problems with the system. Anticipated problems may or may not occur. The proposed review system is designed to deal with the anticipated problems.

Additional information may be obtained from any of the Foundation's regional offices about the exact nature of the review to be conducted in your region.

compac report

WHY COMPAC?

"Politics ought to be the part-time profession of every citizen."
President Dwight D. Eisenhower.

Your Colorado Medical Society Political Action Committee (COMPAC) is a valid response to President Eisenhower's admonition. The purpose of the PAC is: (1) to promote and strive for the improvement of government by encouraging and stimulating organized medicine and others to take a more active and effective part in governmental affairs; (2) encourage physicians and others associated with the profession to understand the nature and actions of their government, including important political issues, and to elect or re-elect individuals who demonstrate an attitude for providing the best medical care for our citizens;, and (3) assist physicians and others in organizing themselves for more effective political action and to carry out their civic responsibilities.

Approximately 225 CMS members have responded to the need for political effectiveness by joining COMPAC. That's a small percentage of our membership!! If you have not joined COMPAC for 1984, do so today. 1984 promises to be a major election year - a number of long-time state legislators have already announced that they will not seek re-election and we need to be instrumental in assuring that qualified candidates are selected and have funds available for a successful race.

Campaigns are expensive and few candidates have the personal funds to finance these endeavors. 1980 campaign costs for a seat in the Colorado legislature ranged from $2,500 to $30,000. Candidates from rural areas who do not have to compete in a primary race are at the low end of the spectrum while successful metro area candidates with primary races must expend many more dollars.

Your 1984 COMPAC membership can be forwarded to: COMPAC, P.O. Box 18188, Denver, Colorado 80218.

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Family Membership $75.00
Single Physician Membership
..... $50.00
Single Auxilian Membership $35.00



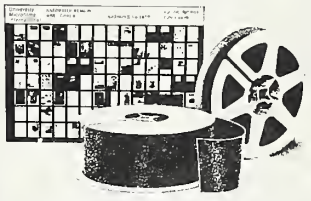
H.R. Safford, III, MD, Chairman
Lorraine Koehn, COMPAC staff assistant

Few candidates have enough personal funds to finance their campaigns.

Important Political Dates for 1984

April 5
Elector must be resident of precinct 32 days to be eligible to vote in caucus
May 8
Precinct caucus day
May 17–June 6
First and last days to hold county assembly
June 13
Earliest day to apply for absentee ballot for Primary Election
July 10
Branch registration offices open for Primary Election
July 18
Last day to hold district and state assemblies
August 8
Earliest day to apply for absentee ballot for General Election
August 10
Last day for Colorado residents to register for Primary Election
August 10
Last day to change party affiliation to vote in Primary Election
September 7
Last day to apply for absentee ballot for Primary Election
September 11
Primary election
September 12
Registration opens after Primary Election
October 5
Last day for Colorado residents to register for General Election
November 2
Last day to apply for absentee ballot for General Election
November 6 1984
General election

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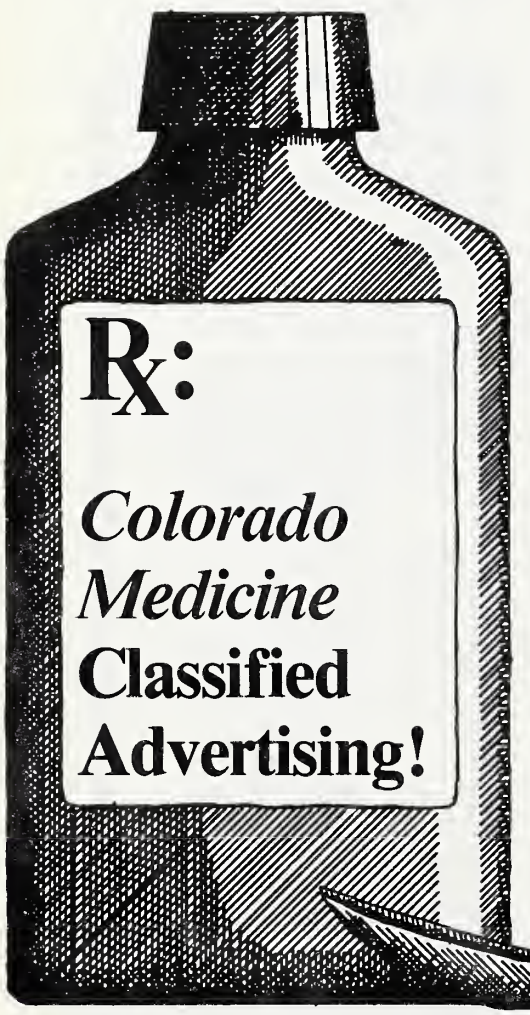


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An Appeal from the BME to Expert Witnesses

Ed. Note: The following article was written by Robert T. Longway, Administrator of the Colorado State Board of Medical Examiners.

At its October meeting, the Colorado State Board of Medical Examiners discussed the use and payment of expert witnesses in disciplinary proceedings. After hearing testimony from Department of Regulatory Agencies' staff regarding sharply escalating hearing costs, the board indicated its strong support for efforts by the Department of Regulatory Agencies and the attorney general's office to reduce these expenses.

In July, 1982, the Board of Medical Examiners was granted a special two-year appropriation by the legislature to reduce the 45 backlogged cases which had been referred by the board to the attorney general's office for prosecution. The attorney general's office was able to hire several additional attorneys and begin prosecution of cases which were several years old in some cases.

Unfortunately, the legislature did not increase the "hearings" line for the medical board by the same incremental amount as "legal services." This budget line pays for court reports, transcripts, depositions, expert witnesses and other incidental hearing expenses. Therefore, it is important for the Board of Medical Examiners to curtail hearing expenses by all possible means.

Department staff estimate that if we continue to expend hearing dollars at the same rate we did during the first quarter, we will spend $80,000 this fiscal year. We were appropriated $22,000. The department does not possess the resources to increase the hearings line by $60,000 (or $30,000 for that matter). Moreover, in a time of shrinking government budgets, there is no mechanism to supplement this line through the legislature.

Our single largest hearing expense is that of expert witnesses for the Board of Medical Examiners. In one recent medical board case, expert witness expenses totaled over $6,000. For legal reasons, it is essential that we have expert witnesses for almost all medical board cases; in some cases it is necessary to have several. Therefore, we are soliciting the help of those of you who would like to act as an expert witness or who are called to give expert testimony to be as cost-conscious and generous as possible in offering your services to the board.

In reviewing the following list of guidelines for billing, it should be noted that each member of the medical board works on the average of two days each month for $50 per day.

1. Donate as much time as you feel is practical to a case. 2. The board has approved a two-tier scale for billing: $30 per hour for reviewing records, consulting with board attorneys, etc. and $60 per hour for actually testifying. This should be reflected in the new contracts between the attorney general's office and the expert witness. The board is keenly aware that this does not compensate experts at anywhere near the true value of their services. However, it is hoped that Colorado physicians will understand the board's dilemma and assist the board as a matter of professional responsibility and as service to the medical community itself. 3. Do not expand the scope of your examination of the records or background investigation beyond conservative limits without first checking with the assistant attorney general assigned to the case or a member of the board.

The Board of Medical Examiners and the Department of Regulatory Agencies sincerely thank you for your cooperation in this matter.

If you would be willing to act as an expert witness for the medical board, please send a letter to the following address stating your area of expertise and outlining your intentions: Department of Regulatory Agencies, 1525 Sherman St., Room 110, Denver, Colorado 80203, Attention: Robert Longway.

Parents Reminded Of Reye's Syndrome Dangers

Parents should be reminded not to give their children medications containing aspirin for influenza or chickenpox, because of the link between aspirin use and Reye's Syndrome, reports the Colorado Department of Health.

Reye's Syndrome can be a fatal complication of influenza or chickenpox which affects children from infancy through late adolescence, according to Richard Hopkins, MD, chief of the health department's Communicable Disease Control Section. Most cases occur during influenza epidemics in the colder months or during outbreaks of chickenpox which occur in winter and early spring.

Children who receive aspirin while recovering from either influenza or chickenpox are several times more likely to develop Reye's Syndrome than similar children who did not take aspirin, according to studies done by the national Centers for Disease Control. CDC first issued a warning to physicians and parents about the possible link in 1982..

An average of seven to 10 cases of Reye's Syndrome have been reported to the health department annually since it first began collecting the information in 1977, although that number was down in 1982 and 1983. From 600 to 1,200 cases occur each year in the United States, usually in children between ages five and 16. From 20 to 30 percent of those who get Reye's Syndrome die. Permanent brain damage occurs in many others.

According to Dr. Hopkins, until the aspirin connection with Reye's Syndrome is better understood, parents and physicians should avoid giving aspirin to children with flu-like symptoms or chickenpox.

HCFA To Issue Medicare Assignment Directories

Health Care Financing Administration (HCFA) has completed the compilation of information on physician assignment practices under Medicare. The Department of Health and Human Services (HHS) is expected to announce soon the availability of directories showing the percentage of Medicare claims accepted on assignment by individual physicians and medical equipment suppliers. The directories will list individual physicians and attribute one of 30 possible specialty codes for that physician. In addition, the list will indicate the frequency with which physicians accept assignment on claims. Directories will list physicians by zip code area in alphabetical order. Copies of the directories will be available at every Social Security office, at many state and local agencies dealing with care of the aging and at Medicare carriers' offices.

Public Health Association Asks for Presentations

The Colorado Public Health Association is requesting short presentations by members and guests for a half-day session at the association's May, 1984 meeting in Vail. The session will be a forum for people interested in public health to share their experiences, e.g. in investigation of disease, program design, lobbying efforts, etc.

The presentations should be no more than 15–20 minutes long, including discussion. Proposals for presentations, (one-half page maximum) should be submitted to Richard Hopkins, Epidemiology Division, Colorado Department of Health, 4210 E. 11th Ave., Denver 80220. Deadline for submissions is March 16. Suggestions for presentations are also welcome.

Medicine and Technology Meet in Pueblo

When you think of Pueblo, what is the first thing that comes to mind? Colorado State Fair? Army Ordinance Depot? Department of Transportation railroad test track? U.S. Consumer Protection Agency? Steel mill? Colorado State Lottery headquarters?

All of these and much more are a part of Pueblo's colorful background; however, many times lost in this Colorado tapestry is the University of Southern Colorado, seriously involved in teaching in the field of medical technology.

On April 5-6, 1984, the Pueblo County Medical Society and the University of Southern Colorado will co-sponsor a two-day conference, "The Future of Medicine: A Technological Prognosis." The seminar will update participants on new medical and health care ideas and techniques brought about by technological developments. Noted national and local faculty leaders will be among those taking part in the conference.

The University of Southern Colorado is Colorado's only polytechnic university and, as such, has a major interest in the interface between medicine and technology. Inspired by USC President Lyle Wilcox, who has a Ph.D. in engineering, the seminar is one of a series of such conferences bringing professionals together with educators and potential user specialists. This program will feature M. Roy Schwarz, MD, Vice Chancellor of Academic Affairs, University of Colorado Health Sciences Center (UCHSC); William Jobe, MD, member of the Board of Directors of Colorado Medical Society and of the Department of Radiology, Swedish Medical Center, Denver; William Hendee, Ph.D., Department of Radiology, UCHSC, William E. Hahn, MD, Professor of Anatomy, UCHSC and William D. Sawyer, MD, Dean, Wright State University Medical School, Dayton, Ohio.

Gerald D. Reilly, MD, President of the Pueblo County Medical Society, has emphasized that the program gives physicians and other health care professionals an opportunity to directly participate in their community activities in this continuing medical education conference, one which will help the participating physician as well as the entire com-



John A. Whitesel, MD, as he announces to Lyle E. Wilcox, President of the University of Southern Colorado the support offered by CMS of the university's conference, "The Future of Medicine: A Technological Prognosis."



l to r, Gerald D. Reilly, MD, President, Pueblo County Medical Society; Lyle E. Wilcox, Ph.D., President, University of Southern Colorado; John A. Whitesel, MD, President, Colorado Medical Society, on a tour of the CT Scan facility at St. Mary Corwin Hospital, Pueblo, as an unidentified CT technician explains the main operating console of the "CAT" scanner.



John A. Whitesel, MD, President of CMS and Tim Roberts, CMS Director of Information Systems and private pilot as they are about to leave Pueblo Memorial Airport for Denver. On this particular February day, Tim flew Dr. Whitesel in and out of Pueblo for two meetings, one at 1:30 p.m. and the other at 7:00 p.m. Flying time from Denver: 35 minutes.

munity. Dr. Reilly pointed out that such participation and support of USC programs will further focus attention on this "valuable Pueblo and Colorado resource."

The conference starts Thursday evening, April 5, with dinner and a keynote address. Participants will be medical doctors, nurses, pre-medical and nursing students, electrical and electronics engineers, medical educators and researchers, medical technician designers and manufacturers of medical instrumentations and hospital administrators.

Colorado Medical Society President, John A. Whitesel, MD, said CMS eagerly supports the efforts of the Pueblo County Medical Society and the University of Southern Colorado, recognizing the need for continuing education in the medical technology field, and encourages all Colorado physicians to take advantage of this singular opportunity.

In his recent State of the State message to the 54th General Assembly, Governor Richard D. Lamm underscored the high technological development necessary for Colorado's continued economic growth. USC President Wilcox, realizing that technological education is the very underpinning of any such growth, made his academic statement very shortly thereafter. In his speech Dr. Wilcox illustrated the way for one of Colorado's cities to lead the way in this "high tech age." He emphasized the fact that one profession can work together, e.g., education and medicine combining in the field of medical technology to keep both professions abreast of educational and medical needs.

If the CF&I Corporation's Pueblo steel mill was the first picture to come to mind with the mention of Pueblo, you were on the right track; however, metamorphosis is taking place. Pueblo can no longer be dependent on heavy industry. Technology has even taken over at "CF&I," resulting in reduction of work forces and closing of furnaces. USC is the home of polytechnic education (including the latest in medical technology), a bright and permanent part of the Colorado tapestry.

NOTE: If you have not received information or registration materials for the April medical technology conference at USC, please call the CMS Member Services office in Denver at 321-8590, or the Pueblo County Medical Society in Pueblo at 542-0106.

The task was to get John A. Whitesel, MD, CMS President, from a noon meeting in Denver to a 1:30 p.m. news conference in Pueblo, then back to Denver for a 5:00 p.m. meeting, and back to Pueblo for his presentation to the Pueblo County Medical Society general membership meeting at 7:00 p.m. That's all in one seven hour period.

When the question was presented to CMS staff members, the consensus was to "ask Tim Roberts." Granted, if there is anyone associated with CMS staff who is accustomed to handling problems requiring tremendous speed of analysis and logic, who would be better qualified than the Director of Information Systems? But he deals in information transportation at remarkable speeds . . . not people transportation! Even so, CMS staff consensus was on the mark. Tim was the one to ask for the solution. More on that in a minute.

About Tim Roberts: he has been employed by CMS since October, 1982, after having worked in industrial computer programming and systems management. His interest in computer logic and all related areas began while he was a junior in high school. As he describes it, his career and professional computer interests have "been like the proverbial snowball rolling down the hill, increasing in speed commensurate with its rapid growth." Tim's interests have not abated. Today, he is the catalyst which brings ideas to fruition in the form of a workable computer program to handle a wide variety of tasks through CMS's data system.

One of the serious shortcomings of the current-day computer revolution is that few, if any, of the people involved are able to stay abreast of the technological advancements of the science. Tim reads both text and journal material vociferously; however, he feels he scarcely touches the surface of today's computer science, and his interests are limited, chiefly, to his direction and programming at CMS. What Tim alludes to are the rapidly developing areas of medical computer technology and the vast array of computer applications in other fields. One of the reasons for the Pueblo County and Colorado Medical Society's support of the USC conference is the recognition of the need for physicians and related health care professionals to be updated in this fast changing technological field.

As to the solution to Dr. Whitesel's transportation problem, Tim Roberts replied "Be at the airport at 12:30 and I'll have you in Pueblo at 1:15. While you hold the news conference, I'll gas up and be ready to take you back to Denver for your 5:00 o'clock meeting. Then, when you get back to the airport at 6:15, I'll be waiting to take you to Pueblo in time for your evening meeting." Tim did not work this out by computer; he also happens to be an accomplished general aircraft pilot, with over 400 hours flight time in single-engined craft, including the turbocharged type which whisked Dr. Whitesel to Pueblo (twice) in less than 45 minutes each trip. Tim is an active member of a Denver-area flying club, and he has the sleek Piper Turbo IV warmed up and idling when Dr. Whitesel arrived at the terminal.

Tim Roberts began his flying days while working for a firm and continuing his schooling in Arizona. His experience has served him (and CMS) well. Someone said "you can't beat a pilot who also uses logic ('. . . reason or sound judgment, as in utterances or actions.')."

Logically, if the weather had been bad, Dr. Whitesel and Tim Roberts would not have made the trip. Suffice it to say, the weather cooperated.

The Doctors Amesse

James J. Delaney, Jr., MD, Historian, Colorado Medical Society

A remarkable era in Colorado medicine ended abruptly and tragically on June 5, 1968 with the untimely death of John Charles Amesse. He had completed his final year of medical school at the University of Colorado and was enjoying one of his favorite pastimes, mountain climbing, before formal graduation ceremonies on June 7. He was killed while climbing on the Flatirons southwest of Boulder. He was awarded his medical degree posthumously. John was born March 11, 1942 in Oakland, California, where his father was interning at the Highland-Alameda County Hospital.

His distinguished father, John Hawes Amesse, MD, also died unexpectedly at the pinnacle of his career on October 6, 1971. He died of a heart attack at home on his day off while talking to a patient on the telephone.

John Hawes Amesse was born into a well-known medical family on May 24, 1915 in Denver. He was locally educated, receiving both his Bachelor of Arts and M.D. from the University of Colorado. After an internship in Oakland, he served in the United States Medical Corps from 1942 until 1947.

His father was a zealous patriot, a recruiter of medical officers for the army and it was only natural that John would join the army during the war. After his internship, he was assigned to the First Cavalry Division and served as a battalion surgeon in the front line aid stations in the South Pacific. He was awarded the Silver Star for gallantry during the invasion of Luzon. John contracted hepatitis during the recapture of the Philippines and was sent home to recuperate. While he was at home recovering, the Japanese surrendered and his leave was unexpectedly canceled. John was reordered to Japan to serve in the occupation forces. He was finally discharged in 1947.



John W. Amesse, MD

He began the general practice of medicine in his father's old office in the Metropolitan Building. He later moved to 18th and Vine. John is described as having been a dedicated physician, a happy, fun-loving person and community activist whom almost everyone liked. It was this dedication to his patients and his community that was to lead him into the most trying days of his life, his years as a member of the Denver School Board. In addition to a full general medical practice, he was active in many community, medical and church organizations.

John was a fairly active Republican and in 1965 the party approached him about running for the Denver School Board. At the time, the only real issue involving the schools was concern about whether teachers should join a labor union. It was easy to convince John to become a candidate by appealing to his concern for his community. He had no idea how this decision was going to change his entire life and make his name a household word in most Denver homes. He unwittingly was to become one of the key people responsible for the institution of school busing in Denver.

Many of John's patients were active in his campaign and he was easily elected to the board. It wasn't long before the issue of segregated schools, which led to forced student busing, came to the foreground and this has remained the school board's dominant problem ever since. There is no room here to review the history of the lawsuit which led to court-ordered busing, but John Amesse was considered to be the swing vote

on the board. Thus, he became the villain to those who opposed busing and the hero to those who supported it. The busing issue was based on the premise of quality education and John spent many hours touring schools in the district and studying reports on quality of education throughout the country. He was appalled by what he saw, influenced by the reports he studied, and distressed by the way black people were treated when he traveled with them, especially fellow board member Rachel Noel. According to his wife, Mrs. Noel had a significant influence on his decisions.

Because of his support of busing, John had to suffer many indignities and the loss of many of his friends. One can scarcely imagine the hate mail and vitriolic phone calls he had to endure. As a physician, he could hardly withdraw to seclusion to protect himself and his family. He declined to seek reelection to a second term to the board in 1971 and retired from the board in May of that year. He was honored for his service by having an elementary school in Montbello named for him. Those who knew John say that the combination of his son's death in 1968 and his trials on the school board led to his early death at the age of 56.

He is survived by his widow, Eloise and a daughter, Carol Toensing, who lives in Boulder. There are no grandchildren. I have visited with his wife who is now married to Dr. F.A. (Gus) Garcia, who recently retired.

John's father, John William Amesse, MD, was as well-known to previous generations of Denverites as his son. John William was born January 15, 1874 in upper Michigan to French-Canadian parents. His family was poor and his future prospects were bleak. However, he was a bright, likable, enterprising kid; he was able to borrow enough money and was smart enough to gain admission to the University of Michigan College of Medicine in 1894. He did well in his studies but had few prospects for practice after he graduated in 1898. He had to return to his hometown and take a salaried position for the local mining company which controlled the town.

This was an impoverished, degrading existence and he longed for something better. In those days, a military commission and an opportunity to practice medicine in the military services was a desirable thing.

John read of an exam to be given in New York for admission to the Marine Hospital Corps, the forerunner of the U.S. Public Health Service. The chances for winning an appointment were slim but he studied hard and borrowed money to make the trip to New York. In his autobiography, available in the CMS archive files, he describes his anxiety and the difficulty of the exam which lasted more than a week. Candidates were dismissed every day if they had not done well enough on the previous day's exam. John successfully completed the exam but returned home not knowing whether he would be given a commission. Because he had not told anyone of the exam to spare himself ridicule if he failed, he had to remain vague about the trip when he returned home.

He went back to work for the mining company for a meager salary. He was bemoaning his bleak future when notice of his successful completion of the exam and his appointment to the Marine Hospital Corps arrived. He was jubilant and soon began a new way of life.

John's work in the Marine Hospital Corps was primarily as a quarantine officer in ports on the west coast, Hawaii, the Phillipines and the Gulf of Mexico. He met his future wife, Mary Maneta Hawes, daughter of another famous Colorado physician, Jesse Hawes, on his way to Hawaii. She was going to Hawaii as a schoolteacher and he met her when they boarded their ship in the harbor. Their courtship, conducted mostly by correspondence, was to last five years. They were married January 11, 1905 in Greeley, Colorado.

The Hawes' first child, Louise, was born January 28, 1906. John was working at Ellis Island at the time. In February, he was ordered to New Orleans, leaving his family in New York because his duty was only temporary. A nurse was employed to help care for his daughter. Unfortunately the nurse had tuberculosis which she transmitted to the child.

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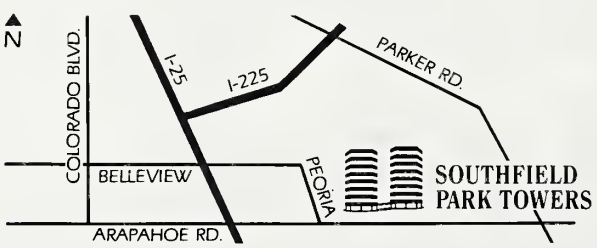
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Louise died of tuberculous meningitis in November, 1906.

John and his wife were devastated. The loss of their child, the prospect for many years of prolonged separation in the Public Health Service and a desire to return to Colorado to help his widowed mother-in-law prompted John to resign his commission. The death of his daughter inspired him to practice pediatrics, so before returning to Denver he took postgraduate training at Johns Hopkins and Bellevue in New York City.

He opened his practice in pediatrics in 1910. He was one of a corps of outstanding pediatricians in Denver at the time. Medical specialization was still in its infancy. He, along with Drs. Gingenbach, Forbes and Barber made Denver a renowned center for pediatric care. Their efforts eventually led to the establishment of Children's Hospital and to one of the earliest pediatric residency programs in the country.

In addition to practicing full time, he, like so many other outstanding physicians, found time to be active in many community activities. He talked Margaret Phipps into establishing a fund to pay for indigent medical and social care for needy children. He was active in the county, state and national medical societies and served as the 69th President of the Colorado Medical Society in 1938.

When America entered World War I, he was quick to offer his services and was appointed the director of Bose Hospital No. 29, the unit staffed by members of the University of Colorado School of Medicine. He saw service both in England and France.

The list of additional endeavors and accomplishments is long and impressive. He was a witty, polished orator and was in great demand as an educator and guest speaker.

John William Amesse died in his home August 27, 1949 at the age of 75. He had been ill for several months with coronary artery disease. He was survived by his son John and daughter Helen, who never married.

Thus, the saga of the Amesse family has ended but the family's influence will long be felt if not remembered.

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Colorado's Low Birth Weight Problem

by Robert S. McCurdy, MD, M.P.H., Director, Medical Affairs, Colorado Department of Health, Clinical Associate, Professor of Pediatrics, University of Colorado Health Sciences Center

Colorado is nationally recognized for its leadership in perinatal care and the reduction of neonatal mortality. Its neonatal mortality rate has fallen dramatically since 1970. To a large extent, this reduction is due to greatly improved weight-specific mortality among lower birth weight infants. This is partially the result of voluntary collaboration among a diversity of health providers, agencies and individuals in Colorado to develop a regionalized system of perinatal care, maternal and neonatal transport and state-wide perinatal education. It should also be noted that under-reporting and inaccurate recording of neonatal deaths in Colorado are minimal.

Unfortunately, however, reduction of the low birth weight rate itself in the last 10 years in Colorado has been relatively slight and has contributed little to the reduction in neonatal mortality. Statistics for 1980 (the latest), show that Colorado's low birth weight rate ranks as one of the seven worst in the United States, and for the white population alone, it is the worst! For all persons, in 1980, the low birth weight rate in Colorado was 8.2 percent, more than 20 percent higher than the U.S. rate of 6.8 percent.

The LBW rate, while poor for the state as a whole, is even higher for the public clinic population in some areas. For example, babies born in Larimer, Boulder and Tri-County prenatal public health clinic populations had LBW rates of 9.9 percent in 1981.

Speculation concerning the small size of Colorado babies is often centered on the high altitude of the state. However, a recent multivariate regression analysis done by the Department of Health failed to implicate any single factor, including altitude, as a principal determinant of low birth weight. Another recent study comparing babies born in Leadville (elevation 10,000 feet) with Denver (elevation 5,280 feet) showed no significant difference in birth weight. Other studies have shown a link between altitude and low birth weight. It may be that altitude is a contributing, but not sole factor in explaining low birth weights. The neighboring states of Wyoming and New Mexico have similar low birth weight rates for whites. However, Utah does not, even though it is a high-altitude state. The effect of altitude on low birth weight is not yet settled and remains an issue of regional Western significance. it seems clear, however, that many factors are involved.

Colorado's relative affluence and high mean educational level provide additional puzzles in explaining the persistence of the LBW rate in Colorado. However, these factors enhance the opportunity to test specific pre-pregnancy and prenatal interventions among high risk populations in the areas of nutrition, smoking prevention and alcohol moderation, and to test other issues such as pre-pregnant weight. Colorado has substantial numbers of women who are not at risk due to various socioeconomic factors, but who are at risk due to their risk-taking behaviors such as poor nutrition, smoking and alcohol use.

Significance

The problem of low birth weight births is an important and complex one. Reducing the incidence of low birth weight infants (2500 grams or less), is a principal goal in improving infant health, particularly in a state like Colorado which has one of the worst low birth weight rates in the country. Neonatal mortality rates are profoundly influenced by the incidence of low birth weight and weight distribution within the low birth weight category. Prevention of

Table 1
Selected Birth and Death Statistics — Colorado and United States

Year	Births	Low Birth Weight Births			Neonatal Deaths		
		Colorado		U.S.	Colorado		U.S.
		Number	%	%	Number	Rate[1]	Rate[1]
1970	41,480	4,002	9.6	8.2	628	15.1	15.1
1975	40,148	3,622	9.0	7.4	383	9.5	11.6
1977	43,056	3,570	8.3	7.3	318	7.4	9.9
1978	44,063	3,617	8.2	7.1	303	6.9	9.4
1979	47,179	3,855	8.2	6.9	300	6.4	8.7
1980	49,716	4,090	8.2	6.8	329	6.6	8.4

[1] Neonatal and Infant Death Rates are per 1,000 live births.

low birth weight, particularly very low birth weight, will reduce neonatal and infant mortality, reduce the need for tertiary newborn services, and thus reduce costs. In addition, the low birth weight baby is at greater risk for subsequent developmental disabilities. Surviving infants weighing less than three pounds at birth are particularly at risk. Approximately 25 percent of these survivors will have significant problems including blindness, various neurologic handicaps and learning disabilities. Other developmental problems linked with low birth weight include cerebral palsy, epilepsy, mental retardation, malformations, brain damage and hearing loss. Adolescent mothers are particularly at risk of delivering a low birth weight baby.

Table 2
Ranking of Low Birth Weight Rates for All Persons by State, 1980

Rank	State	Rate[1]
51	Washington, D.C.	12.8
50	Mississippi	8.7
49	Georgia	8.6
	Louisiana	8.6
	South Carolina	8.6
46	**Colorado**	8.2
	Maryland	8.2
44	Tennessee	8.0
43	Alabama	7.9
	North Carolina	7.9
41	Delaware	7.7
40	Arkansas	7.6
	Florida	7.6

Other rates: Utah 5.2, Arizona 6.2, New Mexico 7.6, Nevada 6.6
[1] Rate is the percentage of low birth weight births to all live births.

Table 3
Ranking of Low Birth Weight Rates for White Persons by State, 1980

Rank	State	Rate[1]
51	**Colorado**	7.9
50	New Mexico	7.6
49	Wyoming	7.2
48	West Virginia	6.4
	Georgia	6.4
	Maine	6.4
	Tennessee	6.4

Other rates: Utah 5.1 (9th best), U.S. 5.3
[1] Rate is the percentage of low birth weight births to all live births.

The cost of providing care to low birth weight infants is high. A study by the Colorado Department of Health estimated life time costs of low birth weight survivors to be more than $40,000 per child in 1983 dollars. For the first year alone, a low birth weight infant costs 11 times as much as the cost of providing adequate prenatal care.

Preventive Activities

As is well known, the LBW rate in the United States is significantly higher than the rates of other developed nations. Reduction of the U.S. and Colorado rates is clearly possible, given a commitment to address factors known to contribute to prevention of LBW. These factors include optimum preconception maternal health, early and adequate prenatal care, adequate maternal weight gain, adequate nutrition, absence of smoking, minimal or no alcohol and drug use, appropriate spacing of pregnancies and prevention of teenage pregnancies.

Recent articles in obstetrical literature have outlined an additional area for the reduction of low birth weight births, namely, the prevention of preterm births through the early detection and management of preterm labor. The initial reports of programs using this method are very promising.

Health promotion and education is a positively regarded field in Colorado, both by the medical community and the general population. The health department has made a strong commitment to health promotion. In addition, CMS has collaborated with the department to sponsor a physician survey on health promotion practices.

Some individual and institutional efforts have already started in Colorado aimed at our low birth weight problem. One is a program in Colorado Springs for early detection and management of preterm labor. Another is a pilot project started by the Colorado Department of Health in the fall of 1983. Over a 3-year period, this program will involve public prenatal and family planning clinics in six areas of the state and will also involve a cooperative effort with private providers during the last year of the project. The goals of the project are to (a) reduce the low birth weight rate among women in six prenatal clinics, (b) implement a low birth weight prevention program in three family planning clinics, (c) to educate public and private health care providers in prevention of low birth weight births, and (d) to develop a model low birth weight prevention program consisting of prenatal risk scales, educational interventions and protocols, and the means to evaluate birth outcomes. The Center for Disease Control in Atlanta has a Pregnancy Surveillance System which will be utilized in collecting pertinent data. Evaluation will relate birth weight and outcome to the mother's level and type of risk before and after intervention. Percent of very low birth weight (less than 1500 grams) will be considered along with low birth weight (less than 2500 grams). The model program will be available as a transferable system for use in public and private health care situations.

An Implementation Advisory Committee has been formed which includes representatives from the Colorado Medical Society, Colorado Ob-Gyn Society, Colorado Academy of Family Practice and other individual and organizational health care providers in the state. The primary role of the Implementational Advisory Committee will take place during the third year of the project as plans are developed to involve private practitioners statewide.

Future Benefits

If, through various prevention and early detection efforts, Colorado could reduce its incidence of low birth weight to the level of other advanced countries, e.g., Sweden, there is potential reduction of 35 percent in our present neonatal mortality rate and in the incidence of handicapping conditions resulting from low birth weight. The impact of such a reduction on the lives of infants, their families, health care providers and health care costs would be highly significant. A nationally recognized peronatal specialist during a recent visit to Colorado stated that "the new frontier in perinatal medicine is the reduction of low birth weight births."

Drug Therapy Questions and Answers

This column is designed to provide Colorado physicians with specific answers to commonly asked questions about drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions published in the column were generated from calls received by the Rocky Mountain Drug Consultation Center. These calls came from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions. The center is open from 8 a.m. to 5 p.m. Monday through Friday, with 24 hour on-call service. The director of the center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine at the University of Colorado Health Sciences Center. The medical director is Earl Sutherland, MD, Ph.D., Assistant Professor of Medicine at UCHSC.

Both of this month's topics were written by Larry K. Golightly, Pharm.D.



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Green Hair

Request:

What can be used to remove the color from hair which has turned green from swimming? Regular swimming three to four times weekly in a public pool has resulted in a greenish tint in the grey hair of a middle-aged woman.

Response:

Green coloration may be imparted to the hair of blond or grey-headed individuals following regular swimming. The green color is probably due to deposition of copper in the hair. Simple in vitro studies have shown that copper, chlorine and acid in combination (but no two of these factors alone) will color blond hair green.[1] Hair analyses of blond children with swimming-associated green hair have demonstrated elevated copper levels.[2] Green hair from shampooing has resulted from leaching of copper from household plumbing following water acidification due to non-pH-controlled fluoridation.[3] A conservative approach to dealing with the problem of green hair is probably appropriate. Several suggestions which have been successful in lessening or alleviating green coloring include the following:[2]

1. Insist on appropriate maintenance of swimming pool chlorination and pay strict attention to proper adjustment of pool pH to prevent corrosion of copper pipes in the system.
2. Avoid use of copper-based algicides in pool water.
3. Carefully rinse, dry, and preferably shampoo the hair after each swim.
4. Wash the hair daily. Alternating with acidic (pH-ballanced) and basic shampoos may be helpful.
5. If the problem is especially bothersome, consider swimming in a different pool or possibly decreasing the duration or frequency of swimming activities.

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Effects of Newer Antihypertensive Agents on Control of Blood Glucose

Request:

Please provide information on the effects of newer antihypertensive agents in diabetes mellitus.

Response:

The following summarizes most of the available data on newer antihypertensives and their effects on control of blood glucose.

1. Beta adrenoceptor blocking drugs

The effects of beta blocking drugs on glucose metabolism are influenced by the ancillary pharmacologic properties of these agents.[1,2] In general, beta blockers prolong the effects of exogenous (or endogenous) insulin. These effects are typically greater with noncardioselective agents (e.g. propranolol, timolol, nadolol) than cardioselective ones (e.g. atenolol, metoprolol). With the exception of heart rate, cardiovascular responses to hypoglycemia may be exaggerated in patients on beta blockers. Sharply

increased systolic and diastolic blood pressures may occur with nonselective drugs due to unopposed alph-adrenergic mediated vasoconstriction. These effects tend to be moderated (slight increases in systolic and diastolic blood pressure) with relatively cardioselective agents because of their lessened interaction with vasodilating beta-2 adrenoceptors. Studies in normal subjects have suggested that drugs with intrinsic sympathomimetic activity (e.g, pindolo, oxprenolol) produce comparatively reduced hormonal and cardiovascular responses to hypoglycemia,[3] although it is controversial whether this is of clinical importance.

2. Amiloride

Effects on glucose are minor in non-diabetics.[4] Overt diabetes mellits may be a predisposing factor to the development of hyperkalemia[5] although in mild or diet-controlled diabetes, such effects are encountered infrequently.[6] The drug manufacturer suggests that this agent should be avoided in diabetics or, if used, with frequent monitoring of serum electrolytes and renal function.

3. Captopril

No unusual untoward effects have been demonstrated in diabetics. Glucose intolerance has apparently not occurred,[7] and the drug exerts little or no effect on blood glucose concentration.[8]

4. Bumetanide

Effects of this drug on carbohydrate metabolism are presently unclear. While hyperosmolar nonketotic syndrom has possibly been associated with this agent,[9] trials in normal volunteers have documented minimal effects on glucose tolerance and plasma insulin, glucagon, and growth hormone levels; effects were virtually the same with furosemide.[10] One recent review cites two foreign-language studies of bumetanide effects in diabetics; in one investigation the drug was "diabetogenic" while in another, it exerted virtually no effect on glucose tolerance.[11] Effects on carbohydrate metabolism are thus inconsistent and probably not of great magnitude.

5. Guanadrel

Adverse effects related to diabetes have, as yet, not been documented with this drug. The most recent clinical trials with this agent, comprising a total of 395 subjects, documented no demonstrable effect of the drug on blood glucose control.[12,13,14,15] Diabetics were included in these trials although their exact numbers and the severity or duration of disease was not discussed.

6. Guanabenz

In a large number of open and controlled trials, guanabenz has not been found to cause any abnormality in carbohydrate metabolism or glucose tolerance.[16] Changes in serum biochemistries are rare.

7. Indapamide

In most clinical trials, no changes in fasting blood sugars have been noted in both diabetics and nondiabetics.[17,18] However, in one investigation[19] of 12 patients with Stratum I (mild to moderate) hypertension, blood glucose levels obtained in the morning after an overnight fast were slightly but statistical-

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ly significantly increased from a pretreatment mean of 93 mg/dL to 113 mg/dL after 24 weeks of treatment. It was not stated whether these patients were diabetic or exhibited diabetic tendencies. One recent case of hyperosmolar non-ketotic diabetic syndrome implicated indapamide as a likely precipitating factor in a 74-year-old woman with no prior history of diabetes.[20] Following the acute episode, the patient remained well controlled with diet and no medications. The manufacturer suggests that blood glucose should be monitored routinely during treatment.

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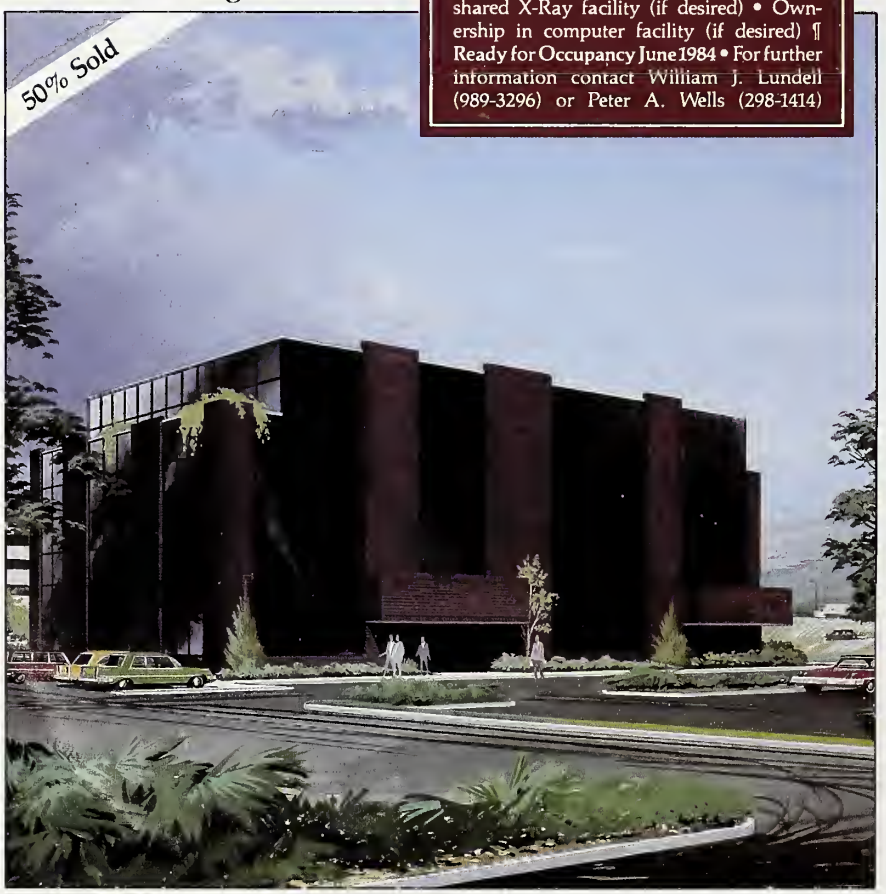
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April

1-4 **Dermatology for the Clinician: Annual Yosemite Symposium** — Ahwahnee Hotel, Yosemite National Park, California. 13 hours credit AMA/CMA Category 1. Fee: $225.00 for physicians and $175.00 for all others. Contact Office of Continuing Medical Education, School of Medicine, TB-150, University of California at Davis, Davis, California 95616. Phone: 752-0328.

2-6 **Postgraduate Course on Clinical on Clinical Management and Control of Tuberculosis** — Denver, Colorado. Tuition:$300.00. 38 hours credit AMA Category 1 and 38 CNA contact hours. Contact the TB Course Office, National Jewish Hospital and Research Center/National Asthma Center, 3800 East Colfax Ave., Denver, Colorado 80206. Phone: (303) 388-4461.

5 **Neuropsychiatric Grand Rounds** — Colorado State Hospital, Pueblo, Colorado. Time: 1-3 p.m. This course was developed by the Colorado State Hospital to examine the relationship between neurological and psychiatric disorders. APA approved course for Category 1 credit. For information contact James H. Scully, MD, 1600 W. 24th Street, Pueblo, Colorado. Phone: (303) 543-1170.

5-6 **The Future of Medicine: A Technological Prognosis** — University of Southern Colorado, Pueblo, Colorado. 4.5 hours of CME credit. Sponsored by the Pueblo County Medical Society and the University of Southern Colorado. Seminar will focus on new thinking and techniques in medicine and health care that have resulted from technological developments. The conference begins at 5:00 p.m., Thursday, April 5 with dinner and a keynote address. For more information contact the Colorado Medical Society Member Services Office, 6825 East Tennessee Ave., Denver, Colorado (Phone: 321-8590) or the Pueblo County Medical Society at 542-0106.

5-6 **Current Practices in Surgery** — University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. AMA and AAFP credit. Fees: $300.00 for physicians and $150.00 for residents and students. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

5-7 **New Diagnostic and Therapeutic Modalities in Cardiovascular Disease - Update 1984** — Doral Inn, New York, New York. For information contact Mary Anne McInerny, Director, Extramural Programs Department, American College of Cardiology. (no telephone number given)

5-8 **Medical Radiation Chemistry and Radiopharmaceuticals** — (one of a series) Governors Court Hotel, Denver, Colorado. 50 hours AMA Category 1 credit. Fee: $500.00. Contact the National Institutes for Professional Education, 4880 River Bend Rd., Boulder, Colorado 80301. Phone: (303) 449-4621 or (800) 421-8452.

6-8 **Cardiovascular Disease: Non-invasive Dianosis Methods** (Stress and Holter ECG) **and Cardiac Rehabilitation** — Doubletree Inn, Denver, Colorado. Contact International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. Phone: (303) 790-8445 or (800) 525-8651.

9-10 **Pediatric Emergencies** — University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. AMA Category 1, AAFP and CNE credit available. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

13 **Pediatric Ophthalmology** — Battenfeld Auditorium, Kansas City, Kansas. 7 hours AMA Category 1 credit. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

13-14 **Implications of the Microcomputer for Speech/Language/Hearing Clinicians** — Battenfeld Auditorium, Kansas City, Kansas. 10 hours credit AMA Category 1 and ASHA. Fee: $50.00. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

14 **Annual Pathology Scientific Seminar** Rieke Auditorium, Kansas City, Kansas. 7 hours AMA Category 1 credit. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

15-18 **American Association of Endocrine Surgeons Annual Meeting** — Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Missouri. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

19-20 **Ventilation/Perfusion and Gas Exchange: A Physiologic Approach** — Granada Royale Hometel, 220 West 43rd St., Kansas City, Missouri. 11 hours credit AMA Category 1 and 9.5 hours AAFP, RT, CRNA and CNE. Fees: Physicians - 2 days $125.00, 1 day $70.00; Nurses and Therapists - 2 days $70.00, 1 day $45.00; Students - 2 days $10.00. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

25-26 **10th Annual Postgraduate Family Practice Symposium** — Battenfeld Auditorium, Kansas City, Kansas. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

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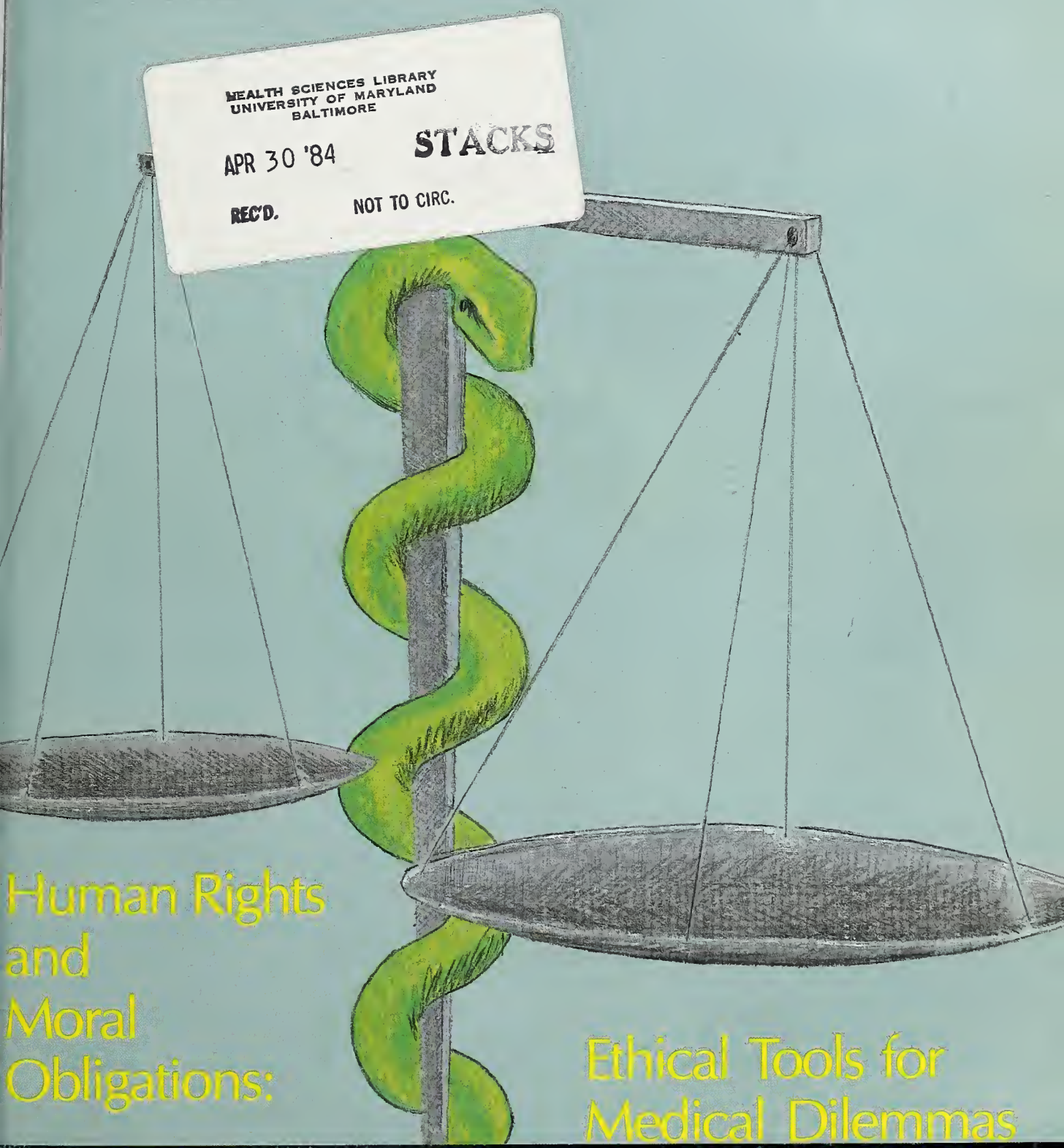
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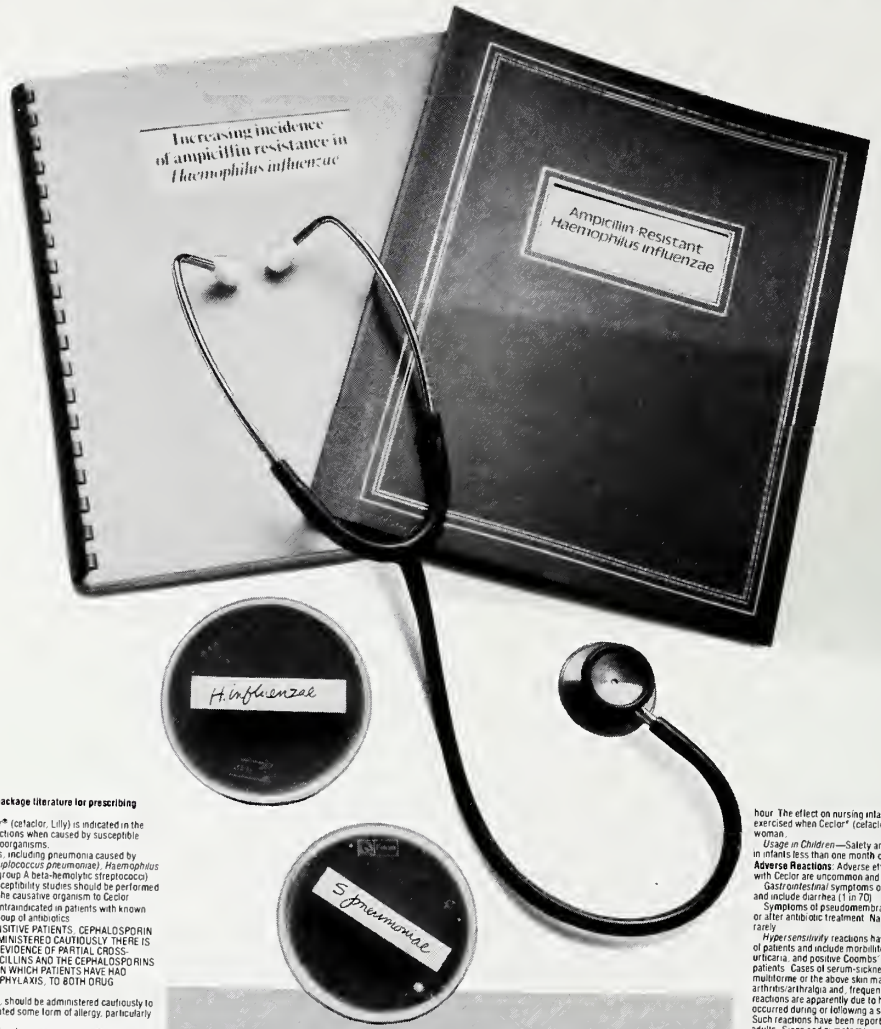
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Human Rights and Moral Obligations:

Ethical Tools for Medical Dilemmas

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs'-testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip; USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

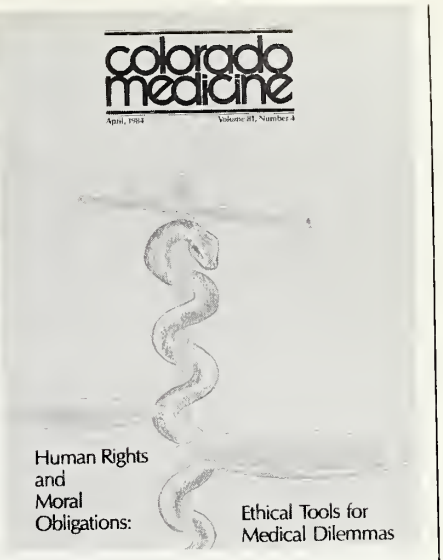
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This Month's Cover:
Society has developed complex medical technology before it has developed the tools for dealing with the technology. How should a physician begin to develop these ethical tools? What resources for studying ethics are available to physicians? What institutions exist to help physicians and patients with ethical decisions? Should a statewide institution be established to debate and adjudicate larger ethical issues, e.g. these which may affect society as well as the individual patient?

Two articles in this month's issue focus on these and other related questions. The first, an interview with Dr. Fred Abrams on medical ethics, begins on p. 105. The second, by Dr. Michael Victoroff, discusses the reasons for and benefits to be derived from a statewide council on biomedical ethics. It begins on p. 107.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

New Dynamics in a Changing Health Care Industry

Restructuring of the health care industry is occurring in response to several forces, principally cost containment. The ideal medical goal of the 1960s—equal access to quality health care for every citizen—is coming into contact with the reality of the 1980s, that this is a fiscal impossibility. This is a commendable goal, but impractical in view of the other priorities of government and business budgets. This realization has been magnified by the recession and runaway inflation that our country has experienced during the past few years. Thus, business and government have come to realize that they cannot pay for all of the medical promises of the 1960s and 1970s (intensive care units, coronary bypasses, dialysis, etc.) and they have begun to restructure the health care system within the framework of cost.

This restructuring has produced prospective payment, withdrawal of funds, institution of deductibles, copayments and user fees. However, many of these architects do not want quality or access to decrease in any degree. Quality, access and cost have been described as an equilateral triangle. Reduction in one side must be followed by reduction in the other two; this is a rather simplified explanation, but is an appropriate analogy. Certainly some costs can be reduced without greatly affecting quality and access, after that point, there will be significant changes. Will these changes be constructive?

Conscientious health care providers, civic leaders, business, labor and government representatives have been re-evaluating costs, procedures, structures and concepts in recent years, in response to demands for cost containment. Progress has occurred and economies have been made. However, the expense of medical care continues to rise due to many factors—demand, technology, energy, wages, etc. The reality of significant cuts in the final medical bill is limitation and/or reduction of access and quality. Rationing is a distinct possibility. These facts must be faced. In response to the nationwide demand for cost-containment, health care providers (physicians, hospitals, nurses, etc.) must be conscious of the effects of new programs and procedures on quality of and access to medical care. The final form being developed must not compromise these areas. All health care providers, and more significantly, health care consumers, should be greatly concerned with the forces working on their health care system, the motives of these forces and the final product they are creating.

New concepts, forms and structures are entering the medical field quite rapidly in response to the demands for fiscal restraint (HMO, PPO, IPA, consolidation or joining of hospitals, hospital corporations and finally prospective payment). To predict the future in this medical kaleidoscope is difficult at best. The constructive results of some of these are data gathering, quality assurance reviews, critical evaluation of change, equipment and procedures. The proper setting for medical care has been reviewed and new concepts for medical care have evolved. Other sources of income are being pursued and suppliers to the health care system are being asked to reduce costs or give discounts.

Positive steps in restructuring the health care delivery system may be considered in several areas affecting both consumers and providers. (See box on next page.)

Arising from these times of change will be new challenges and opportunities for the profession. Patients will become more involved in their own health care and the selection of the place and manner in which it is delivered. Home care and intermediate as well as convalescent care will increase as hospitals attempt to get the patient out of the hospital in the shortest length of time and into a less expensive environment. Collection, evaluation ond review of data concerning office practice, surgical center and hospital administration and treatment will increase many fold, producing more paperwork and stimulating opportunities for objective evaluation in these areas. Outpatient surgery has and will increase at hospitals and surgical centers. Office visits and treatment will rise, as they shift from the hospital. As patient loads diminish and hospitals attempt to cut their overhead, certain services may well be reduced.

Some hospitals will not be able to compete. They will fail or move into other areas. Those hospitals and services remaining will specialize more, depending upon the areas in which the hospital proves to be most economic and effective. There will be a drop in staff nurse positions dealing with direct patient care. Alternative care delivery systems will proliferate and aggressive competition will occur. A rising population in Colorado may ameliorate these anticipated problems, but the common denominator nationwide is the reduction of funding for medical care by the government and business. This cannot fail to reduce present facilities and services, but may stimulate the development of others; the charge to the providers of health care in the 80s is to recognize the changes causing a restructuring of the health care industry, adapt to those that are *positive,* oppose those that are not, and always champion quality and access of health care.

An Outline for Restructuring of the Health Care System

I. CONSUMER/PURCHASER

A. Benefit Redesign—attempts to make consumer involved in purchasing process, sensitive to cost, without reducing the quality and availability. Eliminates benefits which encourage the selection of in-patient high technology services instead of ambulatory and preventive medical care. Stimulates them to evaluate alternative treatment methods—prudent shopper.

1. Consumer cost sharing—Co-payments, deductibles, etc. to eliminate first dollar coverage.
2. Information base—Savings available and comparative costs.
3. Evaluation methods—Second surgical opinions, preadmission certification, etc.
4. Incentives to utilize the most economic setting for health care and behavioral changes for better health care and also disease prevention.
5. Data base for review and management.

B. Alternative delivery systems (HMOs, PPOs, IPAs, etc.)—Response to competition and changes in the health care system. All payment methods—fee for service, capitation, etc. will be reviewed critically and placed in a competitive mode. Different delivery systems will be tried and encouraged. These efforts will provide the consumer and purchaser a choice of types of care and expense to which they will become increasingly sensitive as they become more involved.

C. Health promotion—preventive medicine. Encouragement of preventive health measures and the promotion of the individual's responsibility for his/her health will decrease health care needs, develop public wellness and increase productivity.

Improvement of the individual's environment and lifestyle will be facilitated by:

1. Identification of health risks in the environment and lifestyle and attempt their correction;
2. Education of the individual as to the results of unhealthy practices—economic, social, etc.
3. Rewards for change—lower premiums, recognition, etc.
4. Offer support methods and health programs for change—alcohol, smoking, diet, fitness, stress, environment, work area, substance abuse, etc.

II PROVIDERS

A. Reimbursement system—restructuring the funding of health care from a system which rewards increased consumption of resources to one which promotes optimal, efficient use of resources while maintaining high quality of care.

1. Prospective payment (DRG) breaks link between cost and payment. It will reduce unnecessary services by causing data collection and closer inspection of costs incurred. Prospective payment may cause some limitation of care/treatment to the insured patient but unless provisions are established, potentially there will be a loss of care for the elderly, indigent and long-term care patient. It may produce a regimented assembly line-type delivery system. It can also include incentives which will encourage appropriate utilization and capital expenditures.
2. Capitation—Annual sum for each individual enrolled in a group.
3. Fee for service—Negotiated and discounted for volume.
4. Waivers—To permit reimbursement in less expensive settings.
5. Vouchers—Allow Medicare recipients to shop and different systems bid for these members.

B. Capital regulation—Is felt to be necessary until built into prospective payment. Avoids excess capacity and duplication of facilities.

C. Specific areas

1. Physicians

   a. General—Recommended that physicians be provided with educational, professional and economic incentives for cost-conscious efficient practice and encourage physicians to utilize lower cost, less technological and intensive procedures while remaining consistent with quality of care standards.

   b. Individual effort
      1) Hold down or reduce office expenses
      2) Be accessible
      3) Limit emergency room use—use less expensive area
      4) Encourage disease prevention
      5) Utilize physician assistants, etc. when possible
      6) Use outpatient surgical centers and physicians' offices rather than hospitals when indicated
      7) Promote home care and family responsibility
      8) Discharge patients earlier without compromising quality of care
      9) Physician at risk in hospital costs—general contractor each department a cost center with budget, year end bonus for financial targets met.

2. Hospitals

   a. Make optimum use of existing facilities;
   b. Specialize in care that they are most efficient and cost effective;
   c. Employee incentives for productivity and economic measures;
   d. Data collection and review regarding efficiency of physician, each service, department, etc. (medical staff involvement);
   e. Management/executive bonus program for encouragement of most efficient direction of hospital;
   f. Critically evaluate capital expenditures;
   g. Set performance standards; work toward mutually defined goals in cost containment;
   h. Productivity gain sharing with employees and staff;
   i. Share comparable unit price and efficiency data with public and medical profession;
   j. Legislative efforts to promote the above.

the lobby



M. Robert Yakely, MD, Chairman, Council on Legislation
Carol Tempest, Director, Division of Government Affairs

Successful Legislative Year for CMS

The legislative session is drawing to a close and has been a successful one for CMS. With this being an election year, the legislators are anxious to begin campaigning and will probably be adjourning this month. It's the closing of a book because the makeup of the legislature and its committees will be changed next January.

The following legislators have already announced that they will not seek reelection — and there will be others:

Senator Robert Allshouse (R)
Aurora
Senator Barbara Holme (D)
Denver
Senator Don MacManus (D)
Adams County
Senator Harvey Phelps (D)
Pueblo
Senator Richard Soash (D)
Steamboat Springs
Representative John Davoren (D)
Adams County
Representative Candace Dyer (D)
Longmont
Representative Jean Larson (R)
Colorado Springs
Representative Ruth Prendergast (R)
Denver
Representative Arie Taylor (D)
Denver

Bills followed by CMS have addressed many subjects. Respiratory care practitioners, professional counselors, athletic trainers, and lay midwives all sought certification and were denied. Certificate of Need legislation once more appeared with the thresholds for application being raised, the makeup of the review council being changed, and the hearing procedure made simpler and more fair. A bill concerning temporary licensure of foreign medical school graduates was introduced to help the Health Sciences Center. Two bills written by CMS moved easily through the system — one allowing a physician to serve on a county hospital board and another allowing the insurance commissioner to promulgate rules penalizing insurance companies for delaying payment of benefits.

Our most important effort was in the tort reform arena. CMS helped write three bills addressing the subject and managed to have two of them discussed at length on the House floor. The plaintiff attorney lobby is a powerful one, but public opinion seems to be against the frivolous suits and huge settlements that are taking place. The sponsors of our bills are extremely enthusiastic and feel they have only begun to fight. Many new legislative friends surfaced, and many other lobbyists became allies.

Physicians have been so responsive this year, which makes the job of the Council on Legislation easier. Physicians have appeared at council meetings to share their expertise or to present the rationale for legislation proposed by them. As usual we have had physicians testify in committees on both sides of bills. This confuses the legislators and releases them from a committed vote, but the right of an individual to be heard must always prevail.

This legislative session has been a successful one for CMS.

The Council on Legislation has embarked on a new program, a program that will keep its members busy all year. Each member will be responsible for becoming an "expert" in a particular field of legislation. The fields selected are manpower and financing of medical education, quality of medical care, licensing of allied health professionals, medical indigency, cost containment, civil rights, malpractice, and mandated insurance. Hopefully this project will help us be more proactive instead of reactive to future legislation and insure our having expert witnesses.

Next month's article in *Colorado Medicine* will include a final resume of legislative action and take a look at the role physicians can play in this year's elections.

Rehabilitation Groups of the American Cancer Society

Ostomy Association

With the approval of the attending physician, carefully trained volunteers who have successfully adjusted to ostomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

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Tentative Schedule

Third Annual "CMS Trip to Washington, D.C." May 2–5, 1984

Wednesday, May 2

11:40 am	Depart from Stapleton International Airport on Frontier Horizon Airlines
5:09 pm	Arrive at Dulles International Airport, Washington, D.C. Bus to Capitol Hill Inn
6:00 pm	Check-In at Capitol Hill Inn A tour of AMA headquarters will be arranged for those who have not seen the building.
7:30 pm	Dinner at Maison Blanc (Across from the White House)

Thursday, May 3

8:00 am	Briefing on health issues by AMA staff
9:30 am	Presentation by William Tucker, former Denver attorney and member of President Reagan's White House legal staff.
12:00 noon	Lunch with Colorado Congressmen
1:30 pm	Personal meetings with your Congressmen
4:30 pm	De-briefing and cocktails, CMS suite
6:00 pm	An evening on your own to attend the National Theater, Kennedy Center or view the city by boating down the Potomac for an evening of dinner and dancing (staff will assist you in making arrangements for any of these events)

Friday, May 4

8:00 am	Breakfast at the Democrat Club with Mike McKevitt, former Colorado Congressman; Mr. McKevitt has been the star tour conductor of Capitol Hill landmarks on the past two CMS tours.
11:00 am	Tour of the Supreme Court (hopefully, with Justice White as the tour guide)
12:00 noon	Leave for Bethesda, Maryland for continuing medical education activities
4:00 pm	Return to hotel and a free evening.

Saturday, May 5

8:00 am	Continental breakfast at the CMS suite
8:30 am	Depart for a trip down the Potomac to Mt. Vernon (Arrangements can be made for a White House tour for those interested)
1:30 pm	Return from Mt. Vernon
4:00 pm	Depart for Dulles International
5:30 pm	Depart for Denver via Frontier Horizon Airlines
8:15 pm	Arrive in Denver

Arrangements have been made for individuals wishing to remain in Washington for an additional day. Please contact Government Affairs Division staff for details (321-8590).

Singles: . . . . . $ 850.00
Couples: $1550.00

These prices are subject to change without notice due to air fare increases expected approximately March 15th. Reservations should be made at your earliest convenience to assure the prices listed above. Price includes air fare, hotel accommodations, transportation to and from the airport, dinner at Maison Blanc, two breakfasts, two luncheons, the trip to Mt. Vernon and the registration fee of $200 which should accompany your reservation.

Registration Form for the Third Annual CMS Trip to Washington, D.C.
Detach and forward to Government Affairs Division, Colorado Medical Society, 6825 East Tennessee, Bldg. 2, Suite 500, Denver, Colorado 80224

Name: _____

Address: _____

Home Phone: _____ Office Phone: _____

Please forward additional information on events at the Kennedy Center, National Theater, and the evening trip down the Potomac: ☐

I am interested in touring AMA Headquarters: ☐

I am interested in touring the White House: ☐

Please circle #3 on Reader Service Card

the new Xelan Seminar on Capital Accumulation

Presented by:
L. Donald Guess, DMD
Xelan, the Economic Association of Health Professionals

2½ Hours of Financial Information That Has Helped Other Doctors Accumulate $1,000,000 of Capital

Doctors applying the concepts and ideas presented at this seminar in 1982 experienced:

- An average decrease in annual income taxes of $16,980
- An average increase in annual savings of $38,900
- An average projected increase in saved money at their selected retirement age of more than $1,000,000

Date: Tuesday, April 17, 1984

Place: Denver Hilton Inn South I-25 and Orchard Road Englewood, CO

Time: 7:30 p.m.-9:30 p.m.

Tuition: Complimentary

Reservations: 696-0206

Please circle #4 on Reader Service Card

c.m.e. report



Patrick G. Moran, Chairman, Council on Professional Education; David Haggerty, Director, Division of Professional Services

Council Launches Two New CME Projects

At this writing, the Council on Professional Education is nearing completion on two projects that may have considerable impact on providers of CME in Colorado. First, functioning through its Committee on Accreditation, the council is revising its policies, procedures, and forms pertaining to the accreditation of CME providers (hospitals, specialty societies, etc.) in Colorado. (Accreditation, you will remember, is the process which, among other things, authorizes the provider to certify its various CME activities as meeting the criteria for AMA Category I CME credit.)

The council believes that this project will accomplish two important purposes: 1) it will bring CMS "up to date" in its role as the CME accrediting agency for Colorado, and 2) it will offer much helpful information to and make the accreditation process better, if not easier, for the providers we accredit.

Second, the council's CME Committee is developing a packet of informational materials and application forms for use by organizations/institutions inquiring about possible direct CMS involvement with their educational programs.

The CME Committee's function is different from that of the Committee on Accreditation. The CME Committee deals with issues relating to CMS's role as a CME provider directly accredited by the ACCME, not its role as an accrediting agency. The CME Committee is responsible for certifying the AMA Category I CME credit for all educational activities sponsored by CMS, or jointly sponsored with another organization/institution, if such credit is to be offered. The CME Committee not only has the job of deciding that a particular CME event meets the criteria for AMA Category I, but, as at any CME accredited organization or institution, has to ensure that CMS itself meets the ACCME Essentials for accreditation.

CMS is often approached by non-accredited organizations/institutions with requests to jointly sponsor a specific CME activity, for which CMS would certify AMA Category I CME credit. The CME Committee has developed a set of materials to help such applicants provide correct and complete information so that the request can be properly evaluated and fair decisions can be made. Also, the applicants themselves will receive written information about CMS's policies and procedures to assist them in correctly preparing their applications.

The Council on Professional Education believes that these two CME-related projects, each of which entails some new forms and informational materials, will help CMS better fulfill its dual role as the state's CME accrediting agency and as a nationally accredited CME provider.

Dr. Franklin Yoder will serve on a national CME committee.

More important, we hope it will enable us to provide better services for our membership and constituents.

Questions and comments should be directed to the CMS Division of Professional Services.

Colorado Physician Selected for Important National CME Post

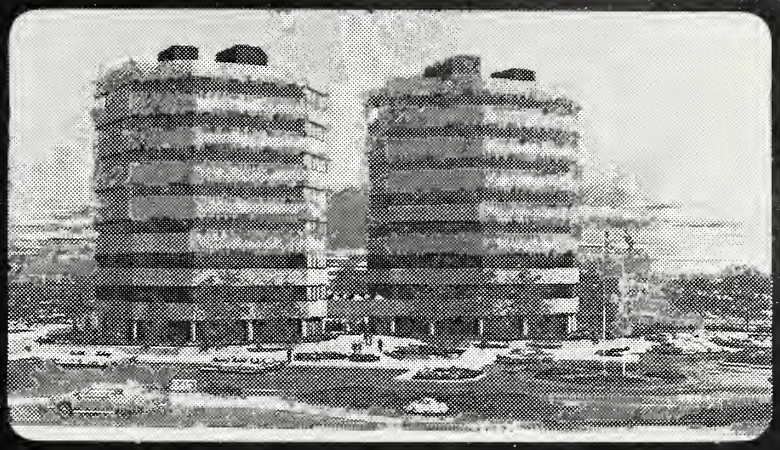
Franklin D. Yoder, M.D., of Greeley, has been selected by the ACCME to serve on its Committee for Review and Recognition (CRR). Dr. Yoder is one of five physicians chosen from nominees submitted by all 50 states for the seven-member committee (the other two members come directly from the ACCME). The CRR, which is to meet annually, will review and act on reports of surveys of state medical societies conducted to assess how they are fulfilling their roles as the intrastate accreditors of CME programs. Nine states will be surveyed each year.

We are pleased and proud that the CMS nominee will serve in this important assignment. Congratulations, Dr. Yoder!

More Conomikes Practice Management Workshops — Mark Your Calendars

CMS will again sponsor the popular Medical Practice Management Mini-Workshops, six in all, presented by nationally known Conomikes Associates, Inc.. The series will be held May 15–18 at the Cherry Creek Inn, Denver. Topics include: Better Collections, Billing and Insurance Methods; Reception and Patient Flow Techniques; Personnel Management Techniques; Personnel Communications and Leadership; Computers in Medical Practice; Practice Marketing Techniques — one or any combination you wish — each workshop is a self-contained unit. Physicians and key office staff are encouraged to participate. Please call immediately if you didn't receive our mailing and want more information: CMS Division of Professional Services, 321-8590.

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Bunkie Inkret, President,
Colorado Medical Society Auxiliary

Rx: Bumblebees and Blockbusters?

Please fill in the blanks by identifying the following:

1. Dillies _____
2. Loads _____
3. 4s and Doors _____
4. Ts and Blues _____
5. Cibas, C.D. _____
6. Bernice _____
7. Nebbies _____
8. Double Cross _____
9. Paradise _____
10. Soaper, Soper _____
11. Beans _____
12. Bennies _____
13. Bumblebees _____
14. Turnabouts _____
15. Roses _____
16. Christmas Trees _____
17. Nimbies _____
18. Redbirds _____
19. Reds _____
20. Yellows _____
21. Block Busters _____
22. Ladies _____
23. Rainbows _____
24. Big C _____
25. Dream _____
26. Girl _____
27. Nose Candy _____
28. Rock _____
29. Snow _____
30. White _____

This quiz is a list of street names for controlled substances frequently written in prescriptions. The answers are: 1 — Dilaudid; 2, 3 — Empirin 4 and Doriden; 4. Talwin and Pyrabenzamine; (2, 3 and 4 are heroin substitutes) 5 — Doriden; 6 and 24 through 30 — cocaine; 7, 9 and 16 through 23 — barbituates; 8 and 11 through 15 — amphetamines; 10 — Methaqualone. How many did you answer correctly?

A few weeks ago, I attended a conference and listened to some high school students discuss their association with the drug scene. One young man described how he had acquired, used and sold prescription drugs; how he had been frightened by an accidental overdose and is now clean. Other students described the drug experiences of close friends. One had a family member who had died from an overdose. Another had a relative who commited suicide because of drugs, and still another had a family member who died in a car accident following drug use.

Prescription drug diversion has become big business.

The students described parties where the attendees brought tranquilizers from home and took them with alcohol or marijuana in order to get a "good high." The recreational use of prescription drugs is concentrated in the population aged 16 to 34. The students said they used drugs to get high, enjoy the feeling and satisfy their curiosity.

Their conversation included the terms in the quiz, which were unfamiliar to me. I realized how unaware I was of the problem and set out to inform myself. The degree to which drug diversion has become big business is truly frightening and almost overwhelming.

Federal data show that prescription drugs are involved in almost 60 percent of all drug-related emergency room visits and 70 percent of all drug-related deaths. Some of these drugs are obtained through wholesale theft and illegal manufacturing, but 80 to 90 percent reach the street through prescription diversion!

Drug addicts and traffickers take the risks to get prescription drugs because of the drugs' purity and potential high sales profit. Pushers and users have also become quite sophisticated in acquiring prescriptions for use and resale. For example, the retail value of cocaine is $49 per ounce; the street value is $2,000 per ounce and up. Preludin is 30 cents a tablet. It sells on the street for $10 to $12 a tablet. Dilaudid sells for $50 for two milligrams.

The American Medical Association established an informal steering committee on prescription drug abuse to provide a national resource for problem identification and program development.

The Colorado Medical Society also has a committee, the Prescription Drug Abuse Coalition Steering Committee. The committee is planning a conference for early June to address the problem and develop solutions for prescription drug abuse in Colorado. Our state ranks high in this type of drug abuse.

The committee's goals include the development of methods to detect drug diversion; legislation to help prevent prescription drug abuse and professional and patient education. I hope our goals can be attained quickly so we can eliminate a source of dangerous drugs which is affecting the youth of our country so seriously.

Profile of a "Doer"

Name: David Michael Munch
Age: 30
Place of Birth: Philippines
Occupation: Internist, in practice with two associates
Married: Yes — to Joan, whom he met while they were students in Boulder
Parents: Christopher and Anne Munch. Mr. Munch is a law professor at the University of Denver.
Siblings: Two brothers and three sisters
Education: George Washington High School, Denver; University of Colorado, Boulder; University of Colorado Medical School, Denver.
Honors: Phi Beta Kappa; Graduated from CU Summa Cum Laude.

It seems easy enough to sum up a man's life as a set of statistics. Sunday news supplements, famous whiskey advertisements and the slick magazines do "personality profiles" in this manner all the time. But you can't sum up David Munch's life in a column of statistics. Dr. Munch is the man whose legs were mangled when he rescued a two-month-old infant from an overturned car.

Dr. Munch and his wife were driving east on West Sixth Avenue on the night of February 4 when they spotted a two-car accident. The Munchs pulled over onto the shoulder of the freeway and got out to try to help the accident victims. Dr. Munch discovered a couple, Donald and Connie LaMoureaux, and their infant son, Jordan, trapped in their overturned car.

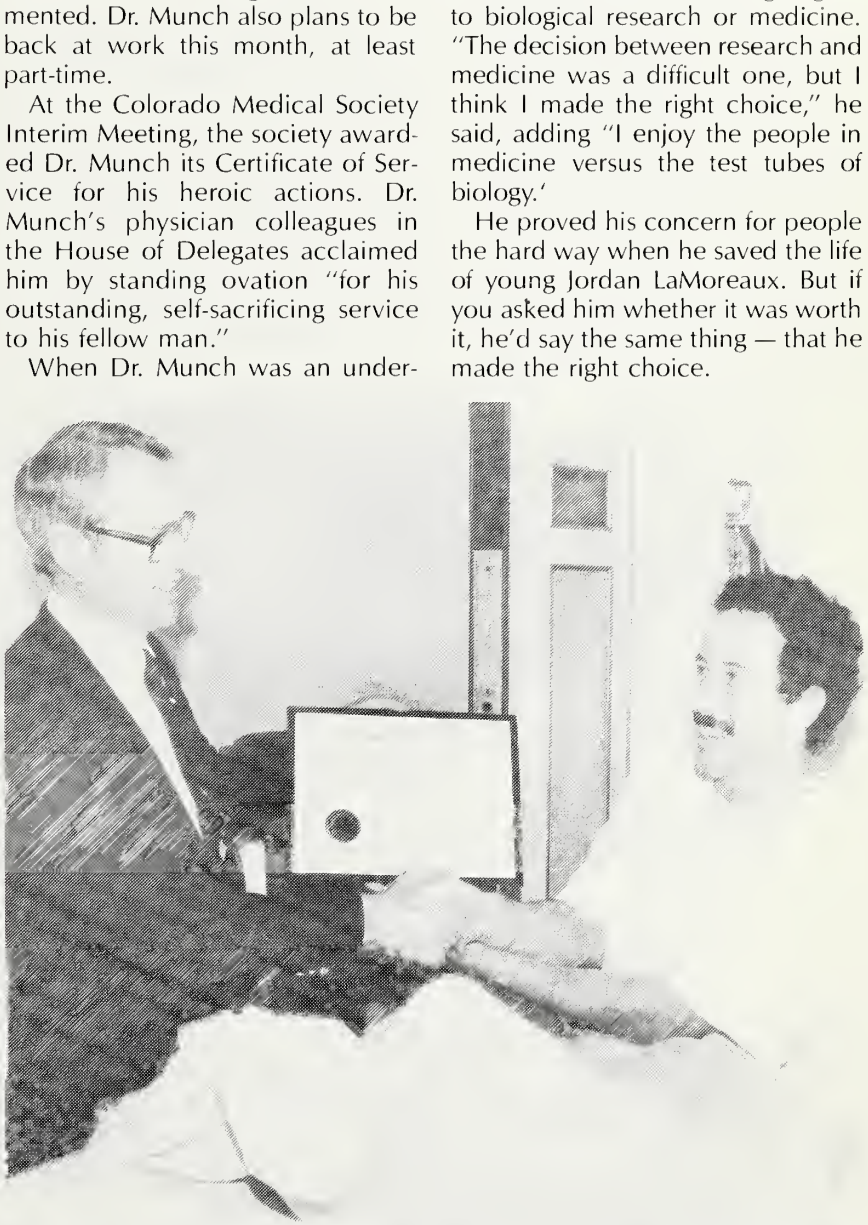
Just as he succeeded in pulling Jordan from the car, a third car careened across the road, hit the LaMoureaux' car and smashed into Dr. Munch. The baby received a skull fracture, but apparently suffered no permanent injury. However, Dr. Munch suffered serious cartilage and muscle damage to his legs. He has undergone several lengthy operations, including skin grafts. He will never again do the running and skiing that he used to love.

However, the accident has not kept him down. The only complaint he has is boredom at being forced to stay in bed. He plans to be walking again within a couple of months and wants to do a lot of swimming and bicycling. "I need something to replace the running," he commented. Dr. Munch also plans to be back at work this month, at least part-time.

At the Colorado Medical Society Interim Meeting, the society awarded Dr. Munch its Certificate of Service for his heroic actions. Dr. Munch's physician colleagues in the House of Delegates acclaimed him by standing ovation "for his outstanding, self-sacrificing service to his fellow man."

When Dr. Munch was an undergraduate at CU studying molecular, cellular and developmental biology, he had to choose between going into biological research or medicine. "The decision between research and medicine was a difficult one, but I think I made the right choice," he said, adding "I enjoy the people in medicine versus the test tubes of biology.'

He proved his concern for people the hard way when he saved the life of young Jordan LaMoreaux. But if you asked him whether it was worth it, he'd say the same thing — that he made the right choice.



President John A.Whitesel, MD, presents CMS Certificate of Service to David Munch, MD, at his hospital bedside March 6. The official award took place March 10 at the Interim Meeting.

Survey Shows Many Colorado Physicians Provide Free Care

A majority of surveyed physicians reported that they provided some free or discounted medical care in 1982, according to a report by the Task Force on the Medically Indigent. In cooperation with the Colorado Board of Medical Examiners and the Colorado Department of Health, the task force conducted a survey of physicians practicing in Colorado.

The survey's purpose was to document the amount of free care provided by physicians in Colorado in 1982. The questionnaire was mailed to all physicians in May, 1983, along with the relicensure application from the BME. A total of 4,640 responses were received; of that number, 2,826 physicians reported that they were self-employed as a primary or secondary activity and practiced either in an office, clinic or hospital. Anesthesiologists, pathologists and radiologists were excluded in the survey analysis, because their practices were considered not to be "office-type."

Almost 74 percent, 2,085 of the physicians surveyed, reported that they provided some free or discounted care, excluding uncollectibles, professional courtesy and Medicaid. Fifty-eight percent stated that one to five percent of their patients were categorized as "no charge."

Receiving payment for medical bills was a problem for many physicians with 66 percent reporting that one to 10 percent of their patients' bills were categorized as uncollectable. The total amount of free, discounted care and write-offs varied among physicians, but 27.4 percent reported that this amount to more than $10,000 in 1982. The total value of free or discounted care and bad debts was estimated to be between $16 and $30 million. More than 80 percent of the physicians reported receiving Medicaid payments for at least one patient in 1982.

Psychiatric Society Members Elected to National Fellowships

Ten members of the Colorado Psychiatric Society recently were elected to fellowships in the American Psychiatric Association. They are: Drs. Charles S. Adler; Michael A. Altman; David U. Caster; Steven L. Dubovsky; Arthur D. Garfein; Herbert Kritzer; Samuel Wagonfeld; Stanley S. Weiss; J. Lawrence Wiberg and Oliver Wolcott.

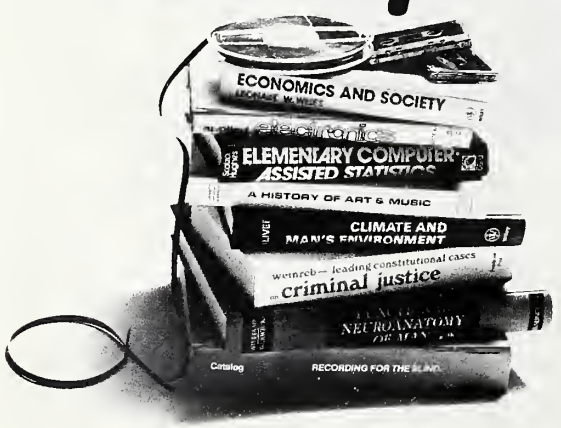
The psychiatrists were elected for outstanding abilities and contributions in several categories including outstanding clinical contributions in psychiatry; administrative achievements in psychiatric services; teaching; research; scholarly publications; active involvement in local district branches or other medical, professional or mental health organizations.

Campaign for Infant "Safety Seat" Loan Program Launched

Under a new Colorado law, all children under four years old or weighing less than 40 pounds must ride in an approved safety seat while in a moving vehicle. Because these seats are not cheap, the Denver Region Nursing Committee of the Mile Hi Chapter of the American Red Cross began a "loan a seat" program in late March. Eighty such programs already exist in Colorado, but only 12 are in the Denver area.

For a small deposit and rental fee, families with young children are able to rent these seats. Cost of the safety seats the Red Cross plans to purchase wholesale are $31.30 for the infant/tod-

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dler style and $17 for toddler seats.

The program is requesting donations from organizations and individuals. Each seat purchased will have the contributor's name permanently displayed on the seat. Persons or organizations interested in making donations should call 399-0550, extension 18 between 8:15 a.m. and 4:30 p.m. Monday through Friday.

Colorado Reports Record Cases of Whooping Cough

A record 138 cases of whooping cough, the highest number in 42 years, were reported in Colorado in 1983. According to Dr. Richard Hopkins, chief of the Colorado Department of Health's Communicable Disease Control Section, the health department will make a special effort to control the disease in the next few years. This will include making sure that new parents know about needed immunizations at the time of their child's birth; helping physicians and local health departments set up tracking systems to ensure that infants complete their first immunizations series before age one; making whooping cough cultures more widely available so that cases will not be missed and following up contacts of cases to identify unimmunized exposed children.

Colorado's present school law requires all children who attend licensed day-care centers and preschools and all children in grades kindergarten through 12 to be fully immunized according to their ages. In contrast to the whooping cough record, no cases of polio, diphtheria, or tetanus, only one case of rubella and three cases of measles were reported in 1983, according to Dr. Hopkins.

Health Department to Participate in Whooping Cough Study

In a related story, the Colorado Department of Health will participate in a two-year study to determine the true incidence of whooping cough (pertussis) in the United States. The health department has requested physician and patient participation in the project. The study will confirm clinical pertussis in participating patients and identify asymptomatic carriers through laboratory services provided free by the Colorado Department of Health. In addition, careful epidemiological follow-up by CDH staff is intended to ensure that both household and other close contacts of pertussis, which otherwise may go undetected, are referred for appropriate treatment.

Colorado is one of three states selected by the Centers for Disease Control to take part in the whooping cough study. The project has been endorsed by the Colorado Council on Public Health. Goals of the study are to generate sufficient data to determine vaccine efficiency, effects of vaccine and antibiotics on disease severity, complication rates from pertussis, health impact of the disease and a case definition which can be formulated for epidemiologic investigation.

Casefinding activities in Colorado will center in Adams, Arapahoe, Denver and Jefferson counties beginning May 1, 1984 until April 30, 1986. The health department requests that pediatricians, family or general practitioners, pediatric hospitals and clinics and emergency room personnel to report suspected cases to the pertussis project coordinator immediately by calling 869-8920 after May 1.

For further information on the health department study, call Barry Krzywicki, the pertussis project coordinator, at 320-8333, extension 3033. For further information about the school immunization law, contact Judy Conner, 320-8333, ext. 3201.



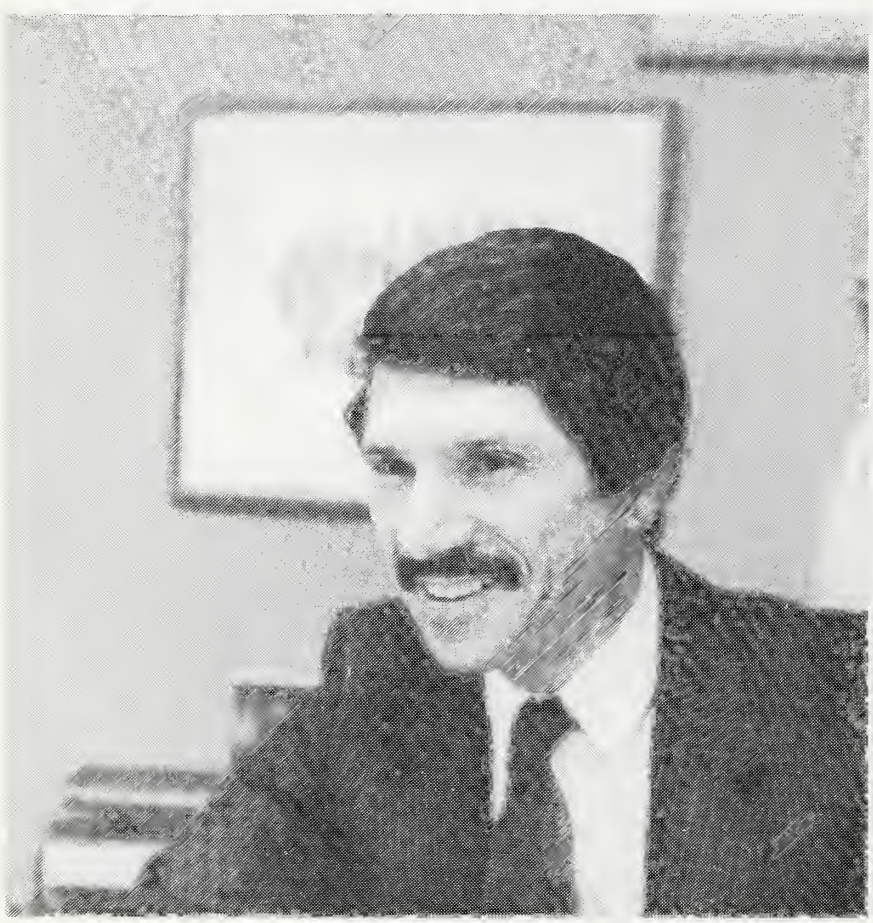
l to r, Gerald D. Reilly, MD, President, Pueblo County Medical Society; Lyle E. Wilcox, Ph.D., President, University of Southern Colorado; John A. Whitesel, MD, President, Colorado Medical Society, on a tour of the CT Scan facility at Parkview Episcopal Hospital, Pueblo, as an unidentified technician explains the main operating console of the "CAT" scanner. Editor's Note: Parkview was incorrectly identified as St. Mary Corwin in an article in last month's issue.

Health Care Cost Containment in Colorado

Editor's Note: The following article was written by George S. Goldstein, Ph.D., Executive Director of the Colorado Department of Social Services. Dr. Goldstein made this presentation to the House of Delegates at the CMS Interim Meeting March 10.

The topic of health care cost containment is uppermost on Governor Lamm's mind lately as evidenced by his recent presentation to the National Governor's Association winter meeting in Washington D.C. on this very subject. The fact that the association had given Governor Lamm, as Chairman of his Human Resources Committee, an entire plenary session to discuss the topic of health care cost containment illustrates the priority given to it by other governors as well. Before sharing with you some of our experiences in this area, I would like to review some of the reasons for the governor's concern.

• Government (federal, state and local) contributes 40 percent of all hospital revenues, 60 percent of all nursing home revenues, and 30 percent of all physician revenues in the United States. This contribution represents 40 percent of health care spending in this country.



• The number of people for whom government purchases health care is increasing. For example, the number of citizens in Colorado over 65 years of age will increase 63 percent between now and the year 2000 (from 246,000 to 401,000).

•In Colorado, the elderly use approximately 40 percent of all hospital care days, 80 percent of all nursing home care, and 30 percent of all physician services. Old age pensioners in Colorado between the ages of 60 and 65 have increased 70 percent over the last year.

•While government is the largest purchaser of health care at 40 percent, business purchases 27 percent and individuals purchase the remaining 33 percent. Between 1977 and 1982, corporate income increased 8.7 percent annually; individual incomes increased 11.2 percent; but hospital costs increased 15.4 percent in Colorado.

•We spent $322 billion on medical care in 1983 or $1,400 for every man, woman and child in the country. At the present rate of increase, in 1990 the annual health care budget will be about $750 billion.

•Chrysler Corporation spent $6,000 on health insurance premiums for an employee in 1983, double the amount paid in 1979. The company calculates that nearly $600 of the price of every Chrysler car and truck is directly attributable to medical costs.

•Nationally, HMO subscribers use hospitals at a rate of 43 percent below the national hospital use rate. If all physicians hospitalized patients at the HMO rate, this estimates we could save as much as $58 billion a year in hospital costs alone.

•Within different locations in a given state, including Colorado, and among persons of a similar age, sex, and health status, the rate of surgery of common procedures can vary up to six times, and the rate of surgery is related to differences in physicians' practices rather than differences in health status.

•Increasing numbers of laboratory tests add $1 billion annually to health costs. One study showed, for example, that the average number of tests for appendicitis increased from five in 1951 to 31 in 1971.

•There are 88,000 excess hospital beds in this country.

There is no doubt in the governor's mind, nor mine, that health care expenditures are out of control and unless we can find a way to control them, we will be leaving an unalterable legacy of a bankrupt health care delivery system for the next generation and generations thereafter. On the national level, the National Governors' Association recently heard testimony which outlined ideal public/private partnerships in Florida, Iowa and other states which leveraged the purchasing power of major employers to significantly reduce health care costs. Governor Kean, Chairman of the Health Sub-Committee of Governor Lamm's Human Resources Committee, and Governor Lamm will be meeting with the National AFL/CIO and other major unions, the National Chamber of Commerce, and other national organizations to elicit their help to create a model on the federal level of public/private partnership.

In an effort to focus the energy of appropriate departments of state government on this problem, the governor is now setting specific goals and objectives for health care cost containment in Colorado. These goals and objectives will be comprehensive, including the possibility of establishing a Colorado coalition of public/private health care purchasers. The objectives of this initiative will include modification of the behaviors of the consumers of health care, the providers of health care, the payers of health care, and the insurers of health care. The legal and tax system which creates roadblocks and inhibitions to efficient and effective medicine will also be included. Further, the governor will look closely at the public and private provisions of medical services in Colorado.

The governor's approach to the problem rests upon three basic ways to make health care more affordable: 1) make the cost of production more reasonable; 2) provide health care services more efficiently; and 3) purchase only those services that sustain or improve health.

The governor also views a strong coalition between individuals, business, providers and government to be crucial to any effective cost containment strategy and that such a coalition must have the integrity to take responsibility for future generations.

Government is not alone in its concern. Chief executives of some major manufacturing, utility, and extraction companies are meeting in Colorado to discuss reduction of their companies' health care costs. It is likely that sometime in the near future Governor Lamm's and the private coalition will merge into a single effort. Thus, the essential question becomes not who will reform the system, but how do we reform a health care delivery system that is biased in favor of curative medicine vs. preventive medicine; that focuses on short-term fixes vs. long-term strategies; that provides incentives for the consuming public to overuse the system; and builds too many hospitals, trains too many doctors, and supplies drugs without adequate controls; and that basically takes pride in the reality that health care represents an ever increasing percentage of the gross national product.

In 1975, Dr. George Pickett of San Mateo County, California, and past president of the American Public Health Association, defined three periods of prevention in health care since the late 1800s. Dr. Pickett defined the second stage of prevention as that period between 1940 and 1975 when health care expenditures rose from $3.8 billion annually to over $118 billion. He described this phase of health care as characterized by scientific discoveries and technological development in the production of very modest health gains. It was a period of enormous investment and concentration of capital. It witnessed a conversion of energy from promoting health to promoting the growth of the health care industry. It is our task to redirect that energy.

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Human Rights and Moral Obligations:

An Interview on Medical Ethics with Fredrick Abrams, MD

"Biomedical Ethics: Society's appreciation of human rights and moral obligations within the medical environment."* Fredrick Abrams, MD, is a Denver gynecologist, assistant clinical professor at the University of Colorado Health Sciences Center and Director of the Center for Biomedical Ethics at Rose Medical Center. He received his undergraduate and medical education at Cornell University in New York City. Dr. Abrams did his internship at Letterman General Hospital in San Francisco and residency at Fitzsimons General Hospital in Denver. Currently, he is a member of the Ethics Committee of the American College of Obstetricians and Gynecologists; the Institutional Ethics Committee, Advisory Board of the American Society of Law and Medicine; and historian of the Ethics and Human Values Committee at Rose Medical Center. The interview was written by Colorado Medicine Publications Editor Sheila Swan.

Some years back, Dr. Fred Abrams became acquainted with a young, up-and-coming member of the Colorado House of Representatives. The two became friendly, even took a trip together with their families. Then the young representative took a step which was to influence his political career and have a profound effect on Dr. Abrams' life as well.

He introduced a bill into the state legislature which became the nation's first liberal abortion law. The year was 1971 and the representative's name was Dick Lamm.

Mr. Lamm, of course, served several terms in the state House of Representatives and became governor of Colorado in 1975. Dr. Abrams went on to become one of the state's leading medical ethicists and Director of the Center for Biomedical Ethics at Rose Medical Center. Dr. Abrams marks the change in the state's abortion laws as the catalyst for his interest in medical ethics.

At the time, he says, he felt good about the new law. "Women in untenable positions were given a choice. Nobody thinks abortion is good. But in some cases it may be the better choice."

But then Dr. Abrams noticed a change in attitudes. Some patients were returning for second and third abortions; in effect, using abortion as a birth control method. "Some of the responsibility that goes with freedom was not being honored. To take life lightly is also an unethical posture," he notes.

Dr. Abrams now found himself in an "ethical dilemma; how could I reconcile this situation in my mind?" On the one hand, he says, he could not advocate the attitude these women took toward abortion. On the other hand, he says, "there is a public and private ethic; there are things you would not do yourself, but interfering with another's rights may be more odious."

Seeking to resolve this dilemma, he took a leave from his practice to study ethics. He received a grant from the National Endowment for the Arts and Humanities and Biomedical Ethics. Dr. Abrams also became a participant in a forum on biomedical ethics sponsored by the Kennedy Center for Biomedical Ethics at Georgetown University in Washington, D.C.

During this time, Dr. Abrams met philosphers, historians and others involved in the humanities. He says he realized that his medical training had not prepared him to deal with broad philosphical issues. "I realized I needed an education in the humanities and decided to read and study on my own." Dr. Abrams and others at Rose Medical center with similar interests began to get together to study and discuss ethics. The study group later grew into the hospital's Ethics and Human Values Committee, which in turn evolved into the Center for Biomedical Ethics. The center has become an educating body and has separated from the ethics committee.

In recent years, issues of medical ethics have become more and more a public concern. "Right-to-die", "consent", "allocation of resources"—these issues and more confront health care providers and patients. Society has developed complex medical technology before it has developed the means—the ethical tools—to cope with it. Physicians are faced with many questions and decisions. Following, in brief, are Dr. Abrams' views on several of these issues.

Should a physician be a "gatekeeper" of resources or an advocate of the individual patient?

"There is no question in my mind that a physician should be a patient advocate." It should not be a patient's own physician, he says, who makes decisions, based on availability of resources, about who should receive treatment, or who should live and who should die. In cases where such decisions must be

**from a brochure on medical ethics published by the Center for Biomedical Ethics*

made, hospital ethics committees can play a role.

It behooves society, Dr. Abrams says, to maintain this unique physicians-patient relationship. Trust, he notes, "is the *sine qua non* of the physician-patient relationship."

With the rising costs of medical care, can society afford to provide good health care to everyone? Is health care a right or a privilege?

"We do have enough resources to provide everyone with decent, minimum health care." However, he states, this can only be done by limiting other types of spending, in both the public and private sectors. This would mean a change in society's priorities. "Good health care for everyone is an ethical imperative even if not a right."

Many people see a danger to society and traditional moral values in some of the biomedical research being conducted today, such as "in vitro" fertilization. Should such research be limited?

"We must not limit research. We may, however, limit the products of research." Dr. Abrams notes that research can bring new solutions as well as new problems, and compares the biomedical research being done today to the development of atomic energy. The splitting of the atom brought the potential for nuclear war, but also the potential for the peaceful use of nuclear energy.

There is no doubt that a physician should be a patient advocate.

Should outside parties, such as in the recent "Baby Doe" case, have a right to intervene in the private decision-making between physician and patient?

Anyone involved in the consequences of a situation should have much more to say about the situation than an outsider." Dr. Abrams comments that the burden of proof that the decision on medical treatment is morally wrong should be on the intervening party, not the patients, parents, or physician.

Given the need for organized discussion and deliberation on medical ethics, should the state of Colorado form a council on medical ethics? (See related article in this issue by Dr. Michael Victoroff)

"I'm leery of the idea of a state council." Such a council, Dr. Abrams says, likely would become "an authoritative voice for right and wrong." "Personal, private issues of right and wrong should be settled locally," e.g. through ethics committees at the local hospitals. Ethics committees at the local hospitals share a "commonality of background" and can better understand ethics issues as they relate to the needs, resources, religious values, etc. of their particular institution and neighborhood.

He notes that community forums



are a valuable way for physicians, other heath care workers and the public to exchange information and ideas on medical ethics. He emphasizes that the professions exist to serve the public. "Thus, you've got to know what the public wants. . . dialogue is critical."

What resources are available to a physician interested in studying biomedical ethics?

Dr. Abrams suggests that physicians begin by reading journals and books on the subject. *Principles of Biomedical Ethics,* by Beauchamp and Childress,is a basic text. Journals include the *Encyclopedia of Biomedical Ethics; Hastings Center Report; Journal on Biomedical Ethics; The President's Commission Reports* and the publications of the American Society of Law and Medicine.

He also suggests that physicians become involved with their hospital ethics committees. Currently, he is co-authoring a cassette tape which will contain information on forming institutional ethics committees.

Locally, several organization sponsor ethics seminars and on-going programs. Recently, the Center for Biomedical Ethics and the American Society of Law and Medicine sponsored a national conference, held in Denver, entitled "Ethics on the Front Line of Medical Care." Co-chairman with Dr. Abrams was Alexander M. Capron, Executive Director of the now-disbanded President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral research. The purpose of the conference was to acquaint health professionals with the findings of the commission and to demonstrate their "practical applications in the provisions of medical care in the community hospital."

Good health care for everyone is an ethical imperative.

The Center for Biomedical Ethics holds ongoing courses on biomedical ethics, community programs, such as discussion groups, provides consultation for hospital policy-making and peer review issues, and has developed a comprehensive library of legal and ethical literature on health care issues.

Other recent programs in Colorado include "Medicine, Law, Ethics and Religion: The Next 100 Years," sponsored by the University of Colorado School of Medicine and the Colorado Humanities Program. The conference, held last November at the medical school, provided a public forum for discussion of resource allocation as seen from these four perspectives.

Colorado Medicine will keep our readers informed about other ethics conferences and programs as we learn about them. For more information about the Center for Biomedical Ethics, call 320-2102. If you cannot find the aforementioned journals in your hospital medical library, contact the center or call the Denver Medical Library, 839-6670.

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For the Common Good: A Colorado Council on Bioethics

by Michael Victoroff, MD

Ed. Note: Dr. Victoroff is an active medical ethicist and frequently lectures to physicians and other health care practitioners as well as to civic groups, schools and other organizations on medical ethics. He belongs to several ethics committees and is chairman of the ethics committee of the Perinatal Care Council. Dr. Victoroff is a family practitioner and Associate Clinical Professor in Family Practice at the University of Colorado Medical School.

The recent economic environment has increased interest in access to health care and the utilization of resources. Individual problems usually can be resolved individually; society's interest is served by whatever benefits a particular patient (thus arises the concept of "informed consent"). However, if the issue is of providing hospital care for the poor, or heart transplants for the insured, conflicts within society's own priorities about the common good may supersede the interest of a particular individual.

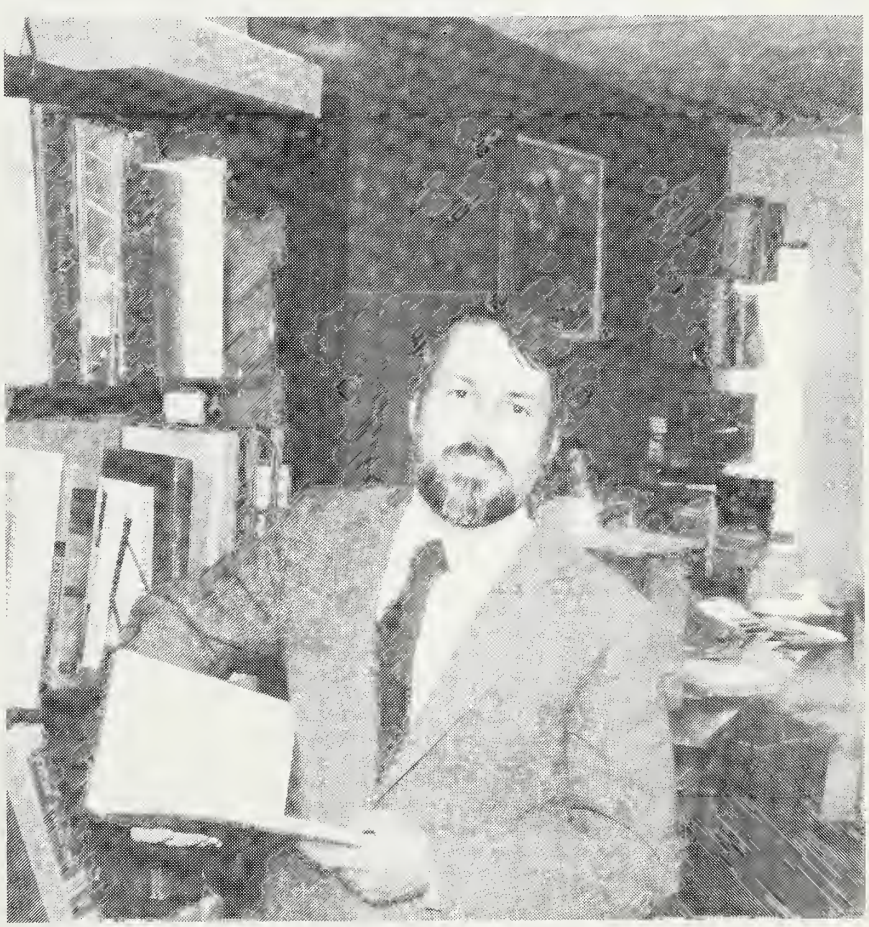
Questions of resource allocation should not be answered within the setting of individual patient care. Often the collective good may conflict with the obvious best interest of a single patient. Neither the treating physician nor the ill patient should be asked to weigh the interests of society against the patient's need. Nor should any single person or small group make "generic" decisions affecting the entire populace.

Yet there must be some level of policymaking at which such conflicts can be adjudicated. Balancing the quality of life against the cost of care must be done at the broadest and most fundamental level of society — not at the bedside.

Current bioethical policies stem from a number of sources. The federal and state governments, hospitals, risk management committees, professional organizations and other institutions all contribute. In the past, courts have been reluctant to intervene in medical practice, but recent cases have changed this tradition. A number of institutional ethics committees have been established, which certainly play major roles within hospitals. However, there is a great deal of confusion about jurisdiction and the scope of authority within these groups.

Additionally, a number of private advisory and study groups, such as the Kennedy Insitute of Bioethics, have contributed enormously to the advancement of bioethical thinking. Several universities have established institutes for bioethical study and some medical schools have designed programs for ethical teaching. The American Society of Law and Medicine has actively promoted ethical problem solving among the professions. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has done much groundbreaking work in approaches to critical problems.

However, several elements are missing, most notably the connection between these groups and the decision-making bodies. Furthermore, since the President's Commission disbanded this year, a major vacancy in bioethical study now exists. It now falls to the states to fill this vacancy. To assist the state and the citizens in this important area, envi-



sion a Council on Bioethics, with advisory authority on all levels of health care practices, policies, regulations and proposed legislation. This group, formed along the lines of the President's Commission, could convene study groups, composed of lawmakers, attorneys, doctors and other health professionals, as well as lay members of the public. Among other functions, it could serve as a clearinghouse for bioethical information, education and research. This council could perform a number of important functions.

First, such a council could collect information on the social effects of new technologies which carry legal and ethical implications, such as in vitro fertilization, as well as to adapt laws, social policies and institutions to new technologies.

Second, it behooves groups who are considering legal aspects of bioethical issues, such as the definition of death, to coordinate their efforts and to develop legal and philosophical compatibility whenever possible. This council could be the coordinating body.

Third, a bioethics council could assist state legislatures to communicate among themselves about matters of national interest in biomedical policy. The group could supply legislators with information about current topics and issues. Another council function might be to maintain a library of appropriate legal and ethical references.

Fourth, the council should offer guidance, supervision and support to institutional ethics committees; devise methods of quality assurance applicable to such groups' operations; help provide the services of ethics committees to hospitals which are too small to support their own committees, which is a majority of Colorado hospitals, and provide a forum in which the methods and protocols of ethics committees can be shared and perfected.

Fifth, an important function of this council should be to promote public understanding and to obtain public input on matters that affect the general welfare, such as decisions affecting the access to health care and the utilization of resources. Sixth, a need exists to monitor, counsel and mediate between agencies and institutions whose activities directly bear on bioethical issues, including malpractice insurers, health insurers, peer-review organizations, the Colorado Department of Health, other regulatory agencies, the courts, hospitals, providers and the public. There is also a need to provide alternatives to the courts for medical litigants, especially on matters related to novel treatments and unprecedented events and to study the ethical and social implications of long-range health plans.

Seven, such a council could act on behalf of the state of Colorado, to represent the interests of the state to the federal government on policy and legislative matters.

The collective good may conflict with an individual patient's best interests.

While numerous entities now work independently on some of these tasks, there is currently no body with the combined authority, credibility and competence to undertake them, on behalf of the people of this or any other state.

A Council on Bioethics, while meeting the needs of communication and coordination cited above, may prove useful and even necessary in time in the resolution of several forseeable problems. The gap is constantly widening between maximal possible therapy, such as artificial hearts and minimal acceptable therapy. As a society we have systematically avoided the question of where to draw the line between the minimal level of care which we may want to guarantee to every person and the ultimate level of care available to selected individuals. Beyond the technical questions which this raises for medical science, the moral and human value issues require intense study. This issue cannot be resolved by the autonomous action of any single group.

Also, malpractice claims and settlements have become a forceful influence on the style and principles of medical therapeutics. Unquestionably, a majority of complaints brought against the medical establishment have their root in actual negligence. Probably, the courts are an appropriate means with which to address these complaints. While such solutions may be satisfactory for most cases, the malpractice industry does not serve, or claim to serve, the more ambitious goal of correcting the deficiencies in the system which permit negligence to occur. Nor does the industry work well in cases of unprecedented or extraordinary events or with broad social issues.

Furthermore, the system of claims compensation is vulnerable to dramatic inequities. It is ironic that, for a variety of reasons, only a chosen few among those claiming damages receive generous compensations, while many with identical or comparable afflictions do not. Whether large settlements are justified in individual cases, the payment of millions of dollars to a select minority stands in glaring contrast to the needs of many for whom a few dollars would make a profound difference. In addition, giant malpractice settlements are a significant factor in the cost of health care. Social expectations about malpractice settlements should be studied.

The utilization of health services is affected by numerous forces. Insurance companies, the medical profession, the public, industry and institutions are trapped in patterns which generate tremendous waste which may divert a staggering amount of money from worthwhile channels. There are few, short-term incentives to reduce utilization and there is almost universal agreement that the system is ethically flawed in major ways.

Yet, autonomous manipulation of the system by one interest group or another may merely disturb the pattern without producing real benefits. Simply deploring the costs of medical care, a fashionable political gambit, ignores the real question of what value our society places on personal health. Developing a new ethic requires the concerted simultaneous action of all parties.

An Agenda for Consideration

1. Does Colorado need a Council on Bioethics? If so, what should its specific charges be? Should this be a government function, a private one or a cooperative effort between the state and private persons or organizations?

2. How should it be funded? If partially or wholly private sources are sought, what provisions can be made to ensure ongoing support? How can undue influence from financial contributors be avoided? How can heterogeneity be assured?

3. What authority should it have? How should it relate to existing agencies, institutions and the state government? Should its authority come chiefly from the credibility of its members?

4. What would constitute an ideal membership and structure? What sort of staff should it employ, with what training and duties? Where should it be located? What would be a reasonable budget?

Suggested Participants

Members of the Colorado legislature
Representatives of the courts, state, county and municipal
The Colorado Department of Health
The Colorado Foundation for Medical Care
Social workers, psychologists and other allied professionals
The Colorado Medical Society
The Colorado Osteopathic Society
The Colorado Nurses Association
The Colorado Hospital Association
The law schools
Representatives of the religious community
Scholars in the fields of ethics, philosophy and sociology
Representatives of the insurance industry
And members of the public at large

Coordinated discussion is needed. Only with open involvement of all parties can meaningful changes be considered.

For some ethical problems, even when reasonably acceptable solutions already are available, e.g. for the refusal of medical interventions by competent, dying adults, the medical profession and the public labor under persistent misconceptions about their legal and ethical duties. Sometimes this causes grossly unnecessary discomfort for all concerned. Clearly, even when society has formed a consensus about an issue, the education of those affected remains a vital task. The nature of consensus on such delicate matters requires that it be represented as originating at the most authoritative levels.

These and other imaginable problems require an interdisciplinary, interprofessional approach. It would be feasible to convene a gathering of interested persons to discuss the usefulness of having a Colorado Council on Bioethics, chartered with the above in mind.

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Drug Therapy Questions and Answers

This bimonthly column is designed to provide Colorado physicians with specific answers to commonly asked questions regarding drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column are generated by calls received by the Rocky Mountain Drug Consutation Center from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The center is available from 8:00 AM to 5:00 PM Monday through Friday, with 24 hour on-call service.

The director of the Rocky Mountain Drug Consultation Center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center and the Medical Director is Earl Sutherland, MD, Ph.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center.

This month's articles were written by Larry K. Golightly, Pharm.D. and Cindi J. R. Gelman, B.S., R.P.h.

Twice A Day Aspirin

Request:

Promotional efforts of suppliers of certain salicylate products are recommending twice daily dosing for patients with rheumatoid arthritis. Can salicylates be used effectively in twice daily regimens for arthritis?

Response:

Salicylates, and aspirin in particular, remain the drug of first choice for treatment of rheumatoid arthritis.[1,2,3] Effective management of arthritic patients generally requires administration of relatively large doses of aspirin (4–6 g/day) preferably adjusted to maintain steady-state serum salicylate concentrations of 150 to 300 mg/L.[4]

Attainment of maximal benefit from aspirin therapy necessitates attention to proper dosage and, therefore, consideration of salicylate kinetics.[5] Following oral administration, aspirin is partly hydrolyzed to salicylic acid presystemically. The remainder of the dose is rapidly (half life 15 min) and completely hydrolyzed to salicylic acid, which exerts virtually all of the anti-inflammatory, analgesic, antipyretic, and the toxic effects of administered aspirin. Salicylic acid elimination is a function of dose and drug concentration due to the limited capacity of the two most important biotransformation pathways, i.e. formation of salicyluric acid and salicyl phenolic glucuronide.[6,7] Enzyme systems responsible for these processes become saturated at body levels of drug well below anti-arthritic amounts. Consequently, steady-state serum concentrations of drug increase much more than proportionately with increasing dosage, the overall rate of elimination of salicylate increases less than proportionately with increasing amounts of drug in the body, and the time required to attain steady-state increases with increasing dose. In practical terms, with high aspirin doses, a 50 percent increase in dose may produce up to a 300 percent increase in serum salicylate concentration,[8] salicylate elimination half life increases to 16–24 hours or more (compared to about three hours with antipyretic doses),[9] and 7–10 days is required to reach the point where serum levels are no longer rising following a dosage increase.

Because of the prolonged elimination of salicylate seen with high doses of aspirin, fluctuations in serum concentration are less rapid than with smaller dosages. Based on these effects, Levy and Giacomini[10] in 1978 provided computer-generated simulations of predicted salicylate levels which suggested that large dosages of aspirin could probably be given to many patients every 8 hours or even every 12 hours without greatly exceeding or falling below the usual therapeutic range. Several clinical reports have subsequently confirmed these predictions. In an investigation of 40 patients with rheumatoid arthritis, 3.9 g/day of aspirin (given either as three 325 mg enteric-coated [EC] tablets four times daily, two 650 mg EC tablets three times daily, three 650 EC tables twice daily, or two 975 mg EC tablets twice daily) produced little fluctuation in serum salicylate levels over the entire dosing interval with no significant difference demonstrated between any of several dosing schedules.[11] Similar results supporting the feasibility of either twice or three times daily dosing for high-dose aspirin have been reported with EC preparations in both adults[12] and children,[13] plain tablets in children[13,14] and in adults using choline magnesium trisalicylate.[15,16,17,18] Large interindividual differences in salicylate elimination suggest that serum concentrations should be monitored during therapy, particularly if a twice daily regimen is used.[19]

While there is a sound pharmacokinetic basis for utilizing an extended dosage interval for salicylates in patients with arthritic conditions, it is important that individual patient tolerance be considered. Gastrointestinal intolerance is the most frequent and usually the most bothersome side effect of salicylates. In addition to dyspepsia, salicylates may cause occult gastrointestinal bleeding and

occasionally erosions with frank hemorrhage through a number of mechanisms including promotion of acid back diffusion, direct irritation with epithelial cell damage and exfoliation, and inhibition of mucus secretion, blood flow, and prostaglandin synthesis.[4,20] Regular use of high-dose aspirin has been found to be a significant risk factor for serious gastrointestinal bleeding leading to hospitalization.[21]

Relatively recent data suggests that the incidence and severity of gastrointestinal irritation and hemorrhage is reduced with enteric-coated aspirin products as compared to plain or buffered tablets. In a study of 94 hospitalized patients given 3–5 g aspirin daily for six days, fecal blood loss measured through radioisotopic chromium labeling of red cells was significantly less with EC aspirin than with several forms of soluble aspirin.[22] Twenty healthy volunteers given 3.9 g aspirin daily as either plain, buffered, or EC tablets underwent upper gastrointestinal endoscopy both before and after seven consecutive days of drug administration; at the end of the trial, observed evidence of gastric and duodenal mucosal injury was significantly less in severity with EC aspirin than with either plain or buffered tablets and only one EC-treated subject had evidence of gastric injury whereas nearly all other subjects clearly developed both gastric and duodenal damage.[23] Similarly, endoscopic investigation of 82 patients with rheumatic disease revealed that evidence of gastric ulceration was present in 23 percent and 31 percent of patients using regular or buffered aspirin, respectively as compared to six percent of patients taking EC aspirin.[24] Thus, when large doses of aspirin are consumed, particularly such as would be required to administer effective antiarthritic doses in two divided portions daily, use of EC aspirin, the newer forms of which have good bioavailability,[25,26] may be recommended because of their comparatively low incidence of gastrointestinal complications.

In summary, pharmacokinetic evidence suggests that twice (or three times) daily administration of high-dose aspirin is feasible in most patients. Individual patient tolerance

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will no doubt determine whether such a regimen can be successfully used. To date, no large-scale, long-term trials have investigated either patient acceptability of these regimens or whether compliance may be enhanced. Long-term effectiveness and safety have not been proven. Nonetheless, in selected patients, twice daily dosing may be more convenient than conventional regimens and therefore beneficial.

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Nicotine Gum:

Request:

Is nicotine gum effective in treating patients who wish to quit smoking?

Response:

Nicotine gum, containing 2 mg of nicotine in an ion exchange resin, is utilized to prevent nicotine withdrawal symptoms (e.g. irritability, headache, fatigue, insomnia). Once the patient has broken the habit of smoking, the gum can gradually be

withdrawn.

Several studies have documented the efficacy of nicotine chewing gum for short-term (less than six months) use, as compared to placebo.[1,2,3,4] However, some long term follow-up studies found nicotine gum to be only marginally more effective than other nonpharmacological approaches.[2,3] Jarvis et al[4] indicate that low pretreatment blood nicotine levels is the best predictor of success at one year follow-up. Others[3,5] have suggested a higher long term abstinence rate in patients using the gum for at least four months.

Blood nicotine concentrations following hourly cigarette smoking are comparable to those achieved with hourly nicotine gum chewing.[6] There is a difference, however, in the time required to reach peak plasma levels. Russell et al[7] reported that peak nicotine levels occur 30 minutes after chewing one piece of gum as compared to 5–10 minutes with cigarette smoking. This difference is due to the smaller absorption area of the oral mucosa as compared to the lungs, and the formulation of the gum in which the rate or vigor of the chewing are controlling factors in the release of nicotine.[8]

The most frequently cited adverse effects of nicotine chewing gum are the unpleasant taste, and irritation of the tongue, mouth, and throat.[8] Less common adverse effects include ulceration of the tongue, jaw aching, flatulence, palpitations, hiccups and nausea.

The manufacturer recommends that when patients have the urge for a cigarette, they chew a piece of nicotine gum unitl they feel a tingling sensation in their mouth. They should then discontinue chewing the gum, placing it between the cheek and gum until they feel the urge for another cigarette, at which time they should again chew the nicotine gum.[9]

Nicotine gum became available in early March by prescription as Nicorette® from Merrell-Dow.

In summary, nicotine gum appears to be effective in quitting smoking. Patients should be instructed on the proper use of the gum and should be made aware that a treatment period of a least four months may be necessary.

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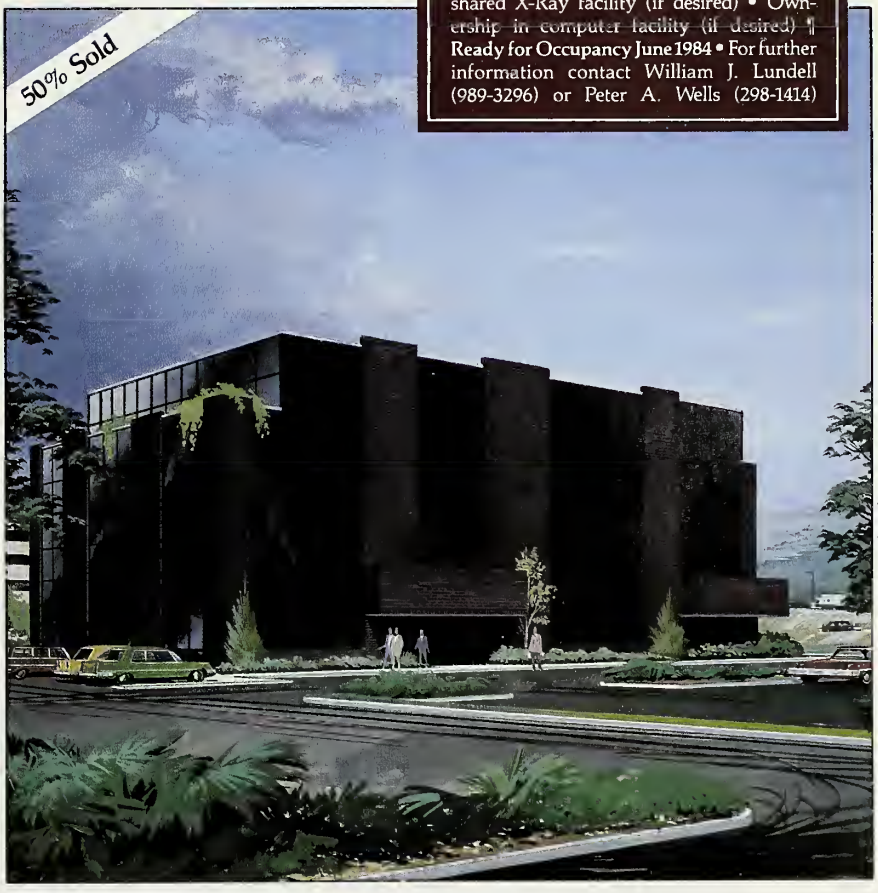
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May

2-6 **Mountain Medicine, 1984** — Stanford Sierra Camp, Fallen Leaf Lake, California. 24 hours credit, AMA/CMA Category 1. Tuition $325.00 for physicians and $180.00 for all others. Contact Ms. Jane Johnson, Office of Continuing Medical Education, School of Medicine, TB-150, University of California at Davis, Davis, California 95616. Phone: 752-0328.

3 **Neuropsychiatric Grand Rounds** — Colorado State Hospital, Conference Room "A", Pueblo, Colorado. Time: 1–3 p.m. APA approved course for Category 1 credit. This course was developed by Colorado State Hospital to examine the relationship between neurological and psychiatric disorders. For information contact James H. Scully, MD, 1600 W. 24th Street, Pueblo, Colorado. Phone: (303) 543-1170.

4 **Cardiac Arrhythmias, Current Trends in Management** — Colorado State University, Fort Collins, Colorado. Northern Colorado Cardiovascular Symposium. Sponsored by Cardiovascular Associates of Fort Collins, P.C. Fee: $50.00 for practicing physicians and $30.00 for physicians in training, nurses and paramedical personnel. Contact the Office of Conferences and Institutes, Colorado State University, Fort Collins, Colorado 80523. Phone: (303) 491-6222.

7-8 **Total Management of the Acute Myocardial Infarction** — Kansas City, Kansas. University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. AMA, AAFP and CME credit available. Two day fees: $200.00 for physicians, $90.00 for nurses. One day fees: $120.00 and $60.00 respectively. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

10-12 **Musculoskeletal Tumor Society Meeting** — Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Missouri. AMA credit available. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

11 **Kansas Medicine, Ten Years Later** — University of Kansas Medical Center, Battenfeld Auditorium, 39th & Rainbow, Kansas City, Kansas. AMA and AAFP credit available. Contact Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, Rainbow at Olathe Blvd., Kansas City, Kansas 66103. Phone: (913) 588-4480.

12 **The Care of Acute Hand Injuries** — 9:00 am–4:00 pm, The Antlers Hotel, Colorado Springs, Colorado. 7 hours credit in AMA category 1 and AAFP prescribed. The key note speaker will be Clifford Snyder, MD, of the University of Utah. Fees: $75.00 for physicians and $40.00 for all others. Contact Lori Guziak, Medical Education, the Department of Medical Education, Penrose Hospital, P.O. Box 7021, Colorado Springs, Colorado 80933. Phone: (303) 630-5184.

15-18 **American Geriatrics Society 41st Annual Scientific Meeting** in association with American Federation for Aging Research — Denver Hilton Hotel, Denver, Colorado. CME credit available. Fees: For May 15-18, member – $125.00; non-member – $150.00; students, interns and residents – $15.00. For May 16-18, $110.00; $135.00; $10.00 respectively. All day Iatrogenic Conference only on May 16 – $50.00. Contact Linda Hiddemen Bardondess, Executive Vice President, American Geriatrics Society, 10 Columbus Circle, New York, New York 10019. Phone: (212) 582-1333.

17-18 **Child Abuse, Behavioral and Developmental Consequences** — Holiday Inn Holidome, Sacramento, California. 12 hours credit AMA category 1 and credit for nurses, social workers, psychologists and probation officers. Tuition: $65.00 for all participants. Contact the Office of Continuing Medical Education, School of Medicine, TB 150, University of California, Davis, California 95616. Phone: (916) 752-0328.

18-19 **Second Annual Horizons in Cardiology** — Sangre De Cristo Arts and Conference Center, Pueblo, Colorado. Sponsored by St. Mary-Corwin Hospital Regional Medical and Health Center, Southern Colorado Clinic and the Colorado Heart Association. Speakers will be C. Richard Conti, MD, FACC, James S. Forrester, MD, FACC and W. Proctor Harvey, MD, FACC. Contact James A. Sbarbaro, MD, FACC, Program Director, St. Mary-Corwin Hospital, 1008, Minnequa Ave., Pueblo, Colorado 81004. Phone: (303) 560-5340.

20-24 **Current Concepts in Primary Care,** 11th Annual Family Practice Refresher Course — Napa Valley Holiday Inn, Napa, California. 26 hours AMA category 1 and AAFP prescribed credit (also acceptable for nurse credit). Tuition $340.00 for all participants. Contact Ms. Jane Johnson, Office of Continuing Medical Education, School of Medicine, TB-150, University of California at Davis, Davis, California 95616. Phone: 752-0328.

23 **Bursitis and Other Aches and Pains** — Salida, Colorado. Speaker: Bruce Dreyfuss, MD. 2 hours AMA category 1 and AAFP prescribed credit. Contact Martin Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, Colorado 80203. Phone: (303) 831-7171

23 **SLE and Related Disorders** — Alamosa, Colorado. Speaker: Bruce Dreyfuss, MD. 2 hours AMA category 1 and AAFP prescribed credit. Contact Martin Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, Colorado 80203. Phone: 831-7171.

25-28 **9th Annual Conference on Neonatal / Perinatal Medicine** — The Lodge at Keystone, Keystone, Colorado. Sponsored by the Section on Perinatal Pediatrics, AAP District VIII. Contact L. Joseph Butterfield, MD, The Children's Hospital, Denver, Colorado 80218. Phone: (303) 861-6509.

28 **What a Non-radiotherapist Should Know About Radiotherapy** — Julesburg, Colorado. Speaker: Michael Stokes, MD. 2 hours AMA category 1 and AAFP prescribed credit. Contact Martin Rubinowitz, MD, The Denver Clinic, 701 East Colfax Ave., Denver, Colorado 80203. Phone: (303) 831-7171.

colorado medicine

May, 1984 Volume 81 Number 5



The "Baby Doe" Issue:

Analysis & Review

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This Month's Cover:
The "Baby Doe" rulings have focused national attention on the dilemma of withholding medical treatment from handicapped infants. These regulations have led to litigation and have pitted right-to-life groups against medical professional organizations. What do these rules say? What are their implications for hospitals, physicians and patients' families? This month two articles address these and other related questions, beginning on p. 109 and 111.

articles

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

Ethics, Priorities and Medical Care

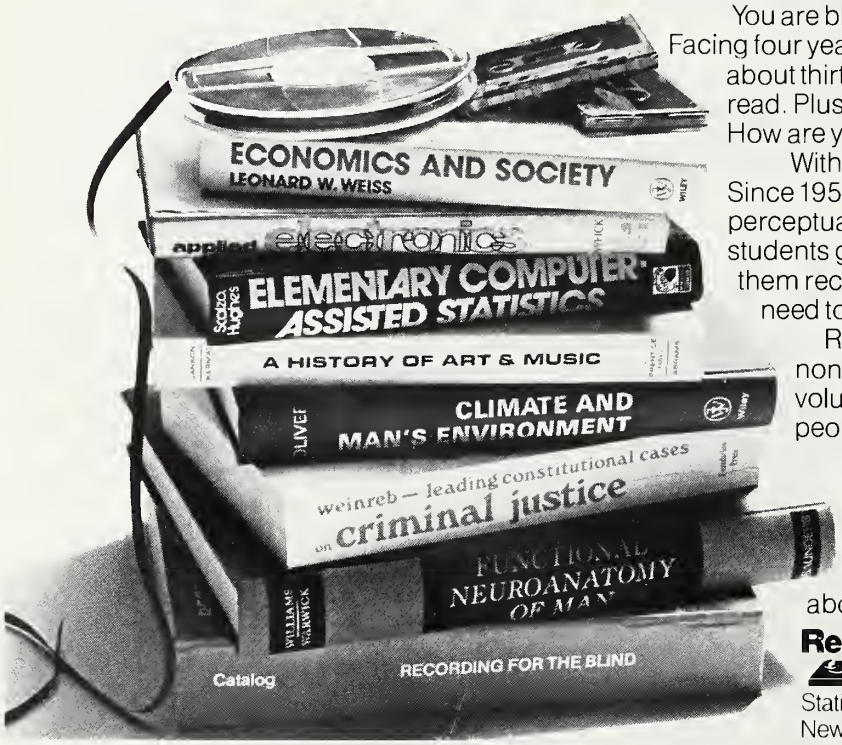
This is an age when millions are spent for ICBMs, space walks, "funny" cigarettes and seven-figure quarterbacks. It is also a time when teachers of our children are poorly paid and given only token recognition, while self-sacrifice and the search for excellence gives way to the "good life" and the pursuit of pleasure. Thus it is not surprising that some public servants pass "Baby Doe" regulations while others tell the elderly that they have a duty to die so that the younger members of society will not be denied. This age then becomes one in which we should reexamine ethics and priorities.

As different concepts and life styles develop, they should not immediately be labeled undesirable, but they should be evaluated critically and placed in perspective. We must measure these ideas and directions next to the ethics that have made us a strong and admired nation in the past, so that we may continue along this ethical path in the future.

Medical care is not immune to change. New relationships as well as technologies are developing every day. They should be measured with the moral values that have stood the test of time. Priorities should be set appropriately. The "brave new world" may not create the medical system that we all desire. Therefore, it behooves us all to pay close attention to what our patients, those in business and in public life are saying about ethics and priorities in medical care. Appropriately, we must be leaders in these areas; if we abdicate this responsibility, we risk losing yet more direction of medical practice.

> We live in an age of ethical incongruities.

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M. Robert Yakey, M.D., Chairman, Council on Legislation
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Legislative Wrap-up

The 1984 legislative session appears to be over with only a short reconvening period left in mid-May during which legislators will consider gubernatorial vetoes and any last-minute issues. In the interim study period, from June until November, an issue critical to medicine will be discussed. The legislators are convinced that some sort of bidding system for pre-paid capitated care will lower health care costs, at least for state-funded programs. CMS worked hard during this session to amend and eventually kill hurriedly-written bills that addressed the subject and will be an active participant in the interim study. A CMS task force has been established and is already active.

We listed last month the names of ten legislators not seeking reelection and mentioned there would be more. Senator Stockton (R), Lakewood, and Representative Lucero (D), Pueblo, have joined the ranks. Representatives Lee (R), Lakewood, Fenlon (R), Aurora, and Wattenberg (R), Walden, have chosen to leave safe House seats and campaign for not-so-safe vacant Senate seats. Rumors abound that others will soon announce that they won't seek reelection but that they didn't want to have lame-duck status while the legislature was in session. Also there are some fascinating and tough primaries in the offing.

So it is a perfect year to be involved in elections. Certainly the presidential battle casts its shadow in Colorado, the Hart campaign is important, and a senatorial battle between Senator Armstrong and his eventual opponent adds fire. Those

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three campaigns, more than the six U.S. House seat races, play a part in victories and losses in state legislative races. There really is a psychological coattail effect that shouldn't happen but does. We urge you to be a part of the political action from the beginning — party caucuses on May 7. Announcement parties this year are more sophisticated than ever before, projected campaign costs are enormous, and our involvement at every campaign level is important. It only takes a phone call to CMS (321-8590) with a request to talk to Lorraine or Carol, and you will be on your way. It's easy, so important, and fun to be a part of CMS's well-organized Participation '84 project!

So let's do a final wrapup of CMS's most successful legislative year:

We finally won a small victory in our tort reform efforts by inserting an exemplary damage phrase in a bill addressing the court's obligation for attorney fees. It is only a beginning, but it was an exciting one. We worked actively to defeat a bill allowing a particular hospital to be an HMO but not fall under HMO laws; another that would have allowed hospitals to hire physicians in order to compete in a prepaid bidding process for patients, and another attempt to recognize lay midwives. All were defeated. We watched other allied practitioners seek recognition and fail without our having to lobby actively. Legislators understandably hate turf battles, and it is best to stay out of them when possible. We also played a quiet role in the annual Certificate of Need battle between the Colorado Hospital Association and the health department. As this article is being written, that bill is still being considered by a conference committee; but it appears that thresholds for application will be raised to $2 million for capital construction and $1 million for equipment, the makeup of the reviewing body will be changed in favor of the providers, and the application system will be simpler and more fair. Death with dignity (or the right to die) was again addressed, and CMS continued to work with Representative Underwood (R), Olathe, on acceptable language. The bill lost but will be back next year, especially after the furor generated by Governor Lamm's recent remarks on "the duty to die".

Party caucuses will take place May 7.

The disappointments were principally two — we are idealists and thus hoped that our entire tort reform package would pass the first year (we'll get more of it next time); and we never find time to help with the many public health issues. The health department has its own lobbyist, but we should be able to be of more assistance.

The greatest success of all was the enormous number of physicians that went to bat this year. That is what made it a winning season and will turn the disappointments into future successes.

WHY AMA?

Today you can have instant access to a broad range of up-to-the-minute clinical information and protocols for use in patient care through the Medical Information Network. This nationwide, computerized system was developed by the AMA, with General Telephone and Electronics (GTE), to provide you with the most advanced, current scientific information. It's one more reason why you should be a part of the AMA.

To Join,
Contact your county or state medical society or write: Division of Membership, AMA, 535 North Dearborn Street, Chicago, Illinois 60610 or call collect, (312) 751-6196.

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Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation group for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit the patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

American Cancer Society
Colorado Division, Inc.
321-2464

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Bunkie Inkret, President,
Colorado Medical Society Auxiliary

Rolling Down The River: A Message from the Auxiliary to CMS Physicians

Recently I attended four days of meetings in Chicago; two days with the AMA Auxiliary and two days at the AMA leadership conference. On the plane ride home, I tried to sort out all the information I had acquired. I realized the tremendous tasks, problems and changes that physicians face in the future. I was overwhelmed!

Then as I sat and pondered, I knew that you as professional men and women would not sit idly by but would, with conviction and resolve, address these issues.

I want to remind you that the CMS Auxiliary, too, is truly interested in the changes in medical practice. The auxiliary membership is composed of skilled, talented, intelligent and willing volunteers who will work with a tenacity equal to yours to solve the problems that physicians face today. We have a personal, vested interest in what happens to medicine. We care how these issues affect you, how they affect us, our families, our friends and our communities.

It is not necessary to reiterate the issues you face. However, when I think about them, I picture physicians on a river, attempting to move logs to a mill. Each of your practice situations determines the number of logs you are responsible to navigate.

Medical Practice Seminar

You are invited to attend a seminar on "INCREASED PROFITABILITY THROUGH COMPUTERIZATION IN PRACTICE MANAGEMENT."

Date: Tuesday, June 12, 5:30 to 7:30 p.m.
Place: Howard Johnson's Motor Lodge
6300 E. Hampden Ave., Englewood

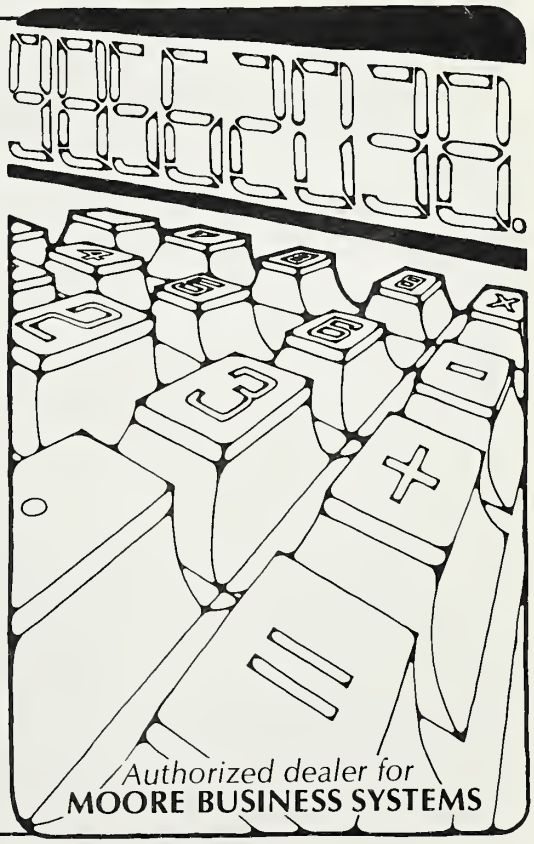
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Are you in group, solo, hospital or HMO practice? Are you in a rural, metropolitan or industrial practice? Are you affiliated with a private, city, state, federal or teaching hospital? What is your specialty? The answers to these questions and many others compose the number of logs you are required to handle in this imaginary trip down the river.

The navigation entails agility. You must move quickly through rapids when the current is swift; steer around rocks; watch for the unknown below the surface; guide your log away from banks and snags and avoid collisions with other physicians and their logs. You must always keep running and balanced on the logs so not to fall in the water. Someone could easily drown without being noticed!

It is impossible to reach the destination without cooperation and we, the auxiliary, are willing to work with you, the medical society, to gain this goal.

I would like to give you an overview of the recent accomplishments of the auxiliary, current programs and future plans. The auxiliary has worked to help make the infant/child safety auto seat program a law. The auxiliary has also promoted health education programs. We are presently involved in voter registration and political campaigns. We are promoting detection and education in prescription drug abuse. We are working on a family solidarity program, hoping to foster more interest in child abuse prevention.

Future goals are to develop and support programs on prenatal and postnatal care. Plans include educational programs on adolescent pregnancy, the fetal alcohol syndrome and hazards of smoking during pregnancy.

A new and exciting program in which we will participate is "media days." You are aware of the importance of good media relations. We hope to develop a national image as volunteers in health promotion programs. Our objective is to create a relationship with the media in two areas; first, by informing them of health-related community service projects and second, by establishing better communication and understanding about malpractice claims.

So because it is impossible for each of you individually to move all the "logs" to their destination, we, the auxiliary, can and will work with you as a unified force.

With the assistance of the auxiliary, organized medicine can coordinate your individual efforts. Organized medicine is needed at county, state and national levels. Under the leadership of your component society presidents, your state president, Dr. John Whitesel and your president-elect, Dr. Gerald Rainer; with supportive and efficient work from your medical society and personal staffs; and with the involvement of the auxiliary, these logs will be properly aligned, securely tethered and moved smoothly to their destination. This can be done with the least amount of your time required. Thus you can do what you do best — care for your patients — for a healthier Colorado.

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Grievance Of The Month

Mrs. Fairfax, a 66-year old Medicare patient, arrived at Dr. Johnson's office for her scheduled appointment. Following a brief wait, she was taken to one of the examining rooms by the office nurse.

Mrs. Fairfax, an established patient of Dr. Johnson's, was a diabetic. However, this particular visit was prompted by complaints of coughing, chills, and heavy congestion.

After a short while, Ms. Smith, Dr. Johnson's physician assistant, entered the examination room. Ms. Smith introduced herself to Mrs. Fairfax and explained that she would be seeing her that day instead of Dr. Johnson. Mrs. Fairfax was aware that Dr. Johnson employed a P.A., but had no previous contact with Ms. Smith.

Mrs. Fairfax appeared somewhat upset by seeing Ms. Smith instead of Dr. Johnson. However, she did not complain at the time.

When Mrs. Fairfax received her statement from Medicare, she was disturbed that it indicated she had been seen by Dr. Johnson, and that the charge for the visit was Dr. Johnson's usual charge.

She immediately contacted the doctor's office to register a complaint, claiming that she thought it was fraudulent to bill Medicaire for an examination by Dr. Johnson when she hadn't even seen Dr. Johnson, and that it wasn't right that the charge for an examination by a P.A. was the same as for an examination by a physician.

Although Dr. Johnson's receptionist explained to Mrs. Fairfax the doctor's policy regarding the use of the physician's assistant and the rationale for the fee, Mrs. Fairfax remained skeptical, and indicated she "would check with the Medicare office."

Dr. Johnson could have avoided this problem with Mrs. Fairfax if he had taken the time to provide a clear explanation to her at the time of her visit. Had he introduced Mrs. Fairfax to Ms. Smith personally, and briefly indicated why he was having the P.A. attend to her and how the billing would appear on the Medicare statement, Mrs. Fairfax would not have interpreted the billing as "fraudulent", and would have been much less likely to have been upset by having been seen by the P.A.

Alliance for the Mentally Ill to Hold Conference

Families and friends of mentally ill persons are invited to attend the Fourth Annual State Conference of the Colorado Alliance for the Mentally Ill (CAMI), to be held from 11:30 a.m. Friday, May 11 through Saturday, May 12 at the Ramada Renaissance Hotel, 3200 South Parker Road, Aurora.

The theme of the conference is "Mental Illness: Hope through Education, Support and Advocacy." Conference workshops and speakers will address a variety of topics including coping with mental illness and housing and treatment of the mentally ill.

Dr. Robert Freedman, Associate Professor of Psychiatry and Pharmacology at the University of Colorado Health Sciences Center will speak at the Saturday conference on schizophrenia.

CAMI is a coalition of 16 support groups of families and friends of the mentally ill and is affiliated with the National Alliance for the Mentally Ill. Its purposes are to encourage the development and expansion of such support groups and to provide a collective voice to address state and local issues on behalf of the mentally ill.

For information call 329-9332 or 237-5419.

National High Blood Pressure Month

May is National High Blood Pressure Month and the Colorado Hypertension Control Program, sponsored by the health department, is joining the national effort to promote hypertension awareness.

The state hypertension program is offering its assistance to health care providers in order to increase the public's knowledge of high blood pressure. The program offers free blood pressure screening at a number of sites in the Denver metro area, free brochures and posters on high blood pressure, a standardized protocol for blood pressure screening and referral guidelines and the 1984 High Blood Pressure Month Kit, which provides ideas for working with patients and the public.

For information contact Linda Dusenberry, 320-8333, 3042.

Human Research Seminar To be Held

The University of Colorado Health Sciences Center is co-sponsoring a seminar on the use of human subjects in medical research. The program, entitled "Human Research: An Informational Dialogue," will take place May 11, at the Cherry Creek Inn from 9 a.m. to 4:30 p.m.

Co-sponsors are the Department of Health and Human Services, Food and Drug Administration; National Institute of Health; Hoffman LaRoche, Inc. and Merck Sharp and Dohme Research Laboratories.

Chairman of the organizing committee is Alan Nies, MD, of UCHSC's Human Subjects Research Committee.

Six hours of Category 1 CME credit is available for physicians.

For information call the Office of Continuing Medical Education, 394-5241.

Prescription Drug Abuse Conference

Colorado Medical Society and the Colorado Prescription Drug Abuse Coalition are co-sponsoring a conference to study the growing problem of prescription drug abuse.

The conference will take place June 14 and 15 at the Clarion Hotel in Denver. Funding for the program comes from the Colorado Attorney General's Public Health Trust and a number of drug manufacturers.

Impetus to produce this conference came from Dr. Tom Vernon, director of the health department, and the Denver Medical Society. The American Medical Association, which has formed an informal steering committee on prescription drug abuse, has provided assistance to CMS in setting up the conference.

Interested physicians should contact David Hlavac at CMS, 321-8590.

Action Against Assault

The Colorado Department of Health is conducting a program to teach children how to avoid sexual assault and what to do if it occurs. The program, coordinated by health educator Debra Sandau, is called "Action Against Assault."

Ms. Sandau developed the unique teaching model last year with the help of Dr. Ron Eager, Dr. Robin Beach and Linda Lenander of Denver Health and Hospitals. The model involves first training a core group of school staff including the principal, key teachers, counselors, school nurses and social workers. They then teach all school staff about sexual assault problems, counseling techniques and available resources for the students. Parents are then invited to a session and given information and suggestions for discussion with their children. Student instruction follows.

At present, six middle schools are involved in the program: Morey, Kepner, Henry, Skinner, Grant and Gove.

"In an estimated 75-85 percent of all child sexual assault cases, the perpetrator is not a stranger," according to Ms. Sandau. "Another disturbing fact is that for every reported sexual assault, at least 10 go unreported."

Medical Assistants to Hold Annual Conference

On May 19 and 20, the Colorado Society of the American Associaton of Medical Assistants will hold its annual meeting at the Quality Motor Inn, I-25 and Speer, in Denver. Registration costs are $35 for members and $45 for non-members, which includes meals and lodging. For information contact Millicent Grant, CMA-A, 1025 Oneida, Denver, Colorado 80220. Or call 388-0102. Registration deadline is May 10.

Hospital/Business Alliance formed in Western Colorado

A model program intended to help save many of the nation's rural hospitals while lowering health care costs for businesses and consumers got underway last month in western Colorado. Pioneers Hospital in Meeker, The Memorial Hospital in Craig, local physicians and businesses joined with one of the nation's largest hospital corporations, American Medical International, and a socioeconomic research firm, National Insititute of Socioeconomic Research, to establish the Craig-Meeker Health Care/Business Alliance. Initial funding for the project was provided by the Association of Western Hospitals.

The alliance will initially provide employees of local businesses with more economical medical coverage than usually can be obtained in rural areas and economic incentives for employees to use the local hospitals.

One of the major program features is the extension of more affordable employee health care benefits to small businesses. Because most of the area's businesses have fewer than 20 employees, they cannot obtain preferential group insurance rates. The alliance expects to serve as many as 2,000 people in its first year through the creation of a multi-employer trust. A one-year demonstration of the program was to begin in April following the selection of a major insurance carrier.

The increased use of local health care services is expected to provide the economic support for upgrading of facilities, services and staff while keeping hospital charges low.

Organizers of the alliance hope that much of the communities' health care may be provided through direct contracts between employers and hospitals during the program's second phase. A flat, annual, per-person fee would cover all doctor office visits, checkups, emergency care and the cost of an insurance supplement for serious illness, injury or treatment not available locally.

Another unusual feature of the program is the pooling of resources by the hospitals to develop specialties that will be shared by both communities.

Craig and Meeker Hospitals have operated well under capacity because many residents prefer to go to larger, often more costly hospitals in cities. Insurance covering these hospital expenses has been an increasing cost to employers in both insurance premiums and employee time away from work.

These conditions have made it increasingly difficult for the hospitals to develop more diversified services which they feel are necessary to compete with larger hospitals. This, in turn, has induced even more residents to go elsewhere for medical care.

For information on the alliance, contact John Osse, chairman and administrator of Pioneers Hospital in Meeker at 878-5047 or Gary Graf in Denver, 623-8421.

Is there a doctor on the road or at the game?



The Committee on Medical Aspects of Sports of the Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

Interscholastic Games: ☐

Running Events: ☐

Names of sports: _____

_____

Please mail to:
David C. Greenberg, MD
Chairman
Medical Aspects of Sports Committee
Colorado Medical Society
6825 E. Tennessee
Building 2, Suite 500
Denver, CO 80224

Name: _____

Address: _____

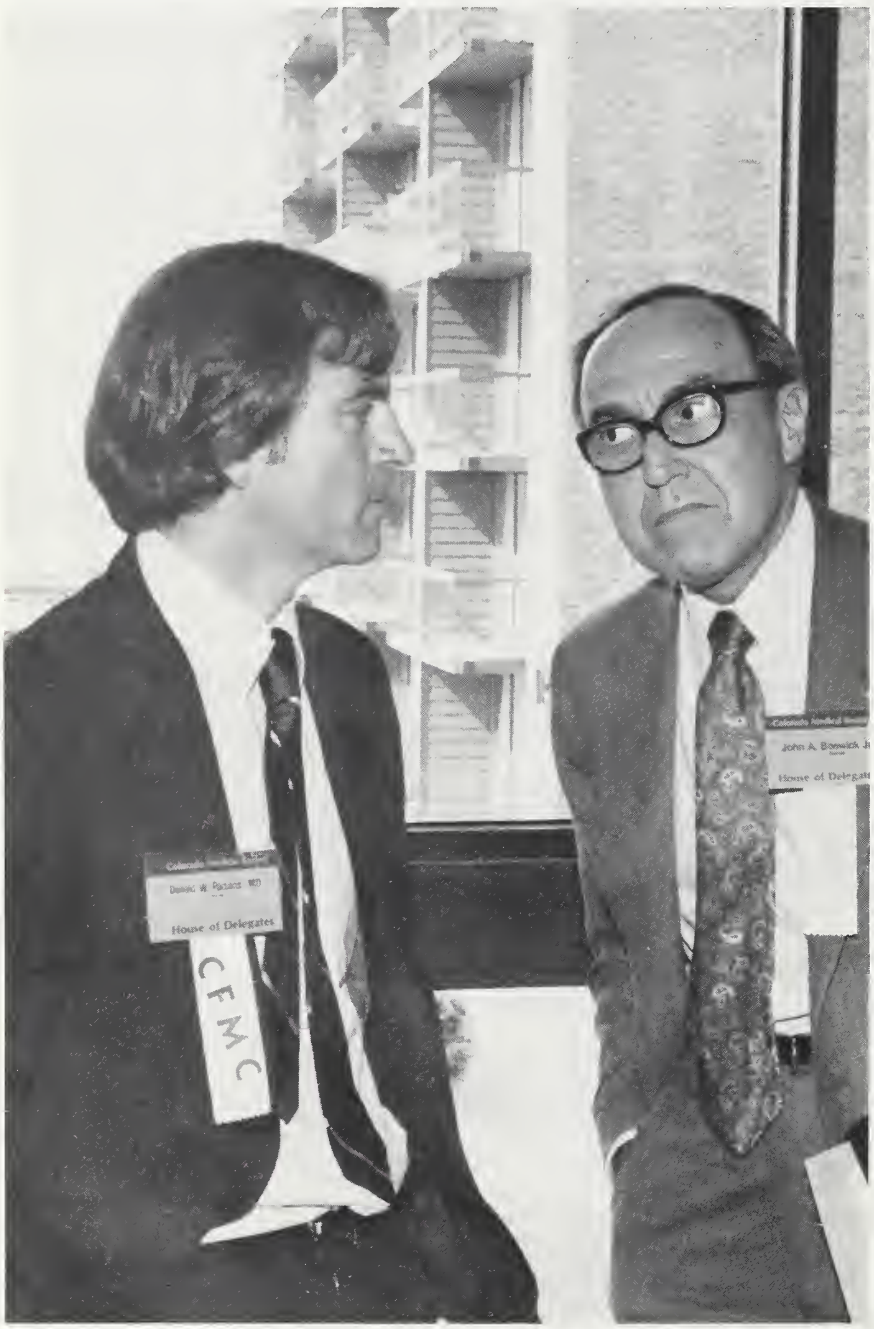
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Highlights of the Interim Meeting of the CMS House of Delegates March 6 and 7, 1984

Ed. Note: Any member interested in seeing a specific report or resolution should call the CMS executive vice president's office at 321-8590.



Organizational

- Approved the progress reports of the Board of Directors.
- Approved the progress report of the Judicial Council.
- Approved the progress report of the Executive Vice President.
- Approved the report of the 1983 AMA Interim Meeting.
- Approved the report of the Member Insurance Benefit Committee.
- Filed the progress report of the Grievance Committee.
- Filed the report of the CMS president.
- Adopted an amended resolution to change the CMS bylaws to provide for representation of the hospital medical staff section in the House of Delegates. The hospital medical staff section will be represented by one delegate and one alternate. Chapter X of the CMS bylaws was amended to reflect the appropriate language necessary to incorporate the new section (HB/Res-1).
- Adopted a substitute resolution as amended that members in the following three categories are exempt from dues: 1) cases of financial hardship or disability; 2) age 65-69 and retired from practice; 3) age 70 regardless of retirement (HB/Res-4 A).
- Adopted a resolution that CMS and component societies no longer bill for AMA dues (HB/Res-5).
- Adopted a resolution amending the CMS bylaws that no dues refund be provided under the following circumstances: if a member is changed from a dues-paying classification during the calendar year for which dues have already been paid; or if a member dies, resigns or transfers to a state that does not accept him gratis for the remainder of the year. Further, that if a CMS member qualifies for emeritus status during the year, he or she be reimbursed for dues paid on a " 'pro rata' basis less any fees established by the Board of Directors for emeritus members." Additionally, a member approved for active emeritus-annual status "shall receive, upon request, a pro rata refund of dues paid" (HB/Res-8).

• Adopted a resolution to publish the CMS Physicians' Directory biennually (L/Res-12).

• Approved the creation of a new component medical society, Mt. Evans Medical Society, primarily representing the geographic area of Evergreen-Bailey, Colorado.

Legislation

• Approved the progress reports of COMPAC and the Council on Legislation.

• Approved the position of the council and the Board of Directors opposing SB 129, which establishes statutory authority to operate alternative health plans, because this is legislation designed to benefit a special interest group. Urged a position in opposition of HB 1180, questioning the financial practicality of this proposal and opposing the concept of hospitals hiring physicians as employees.

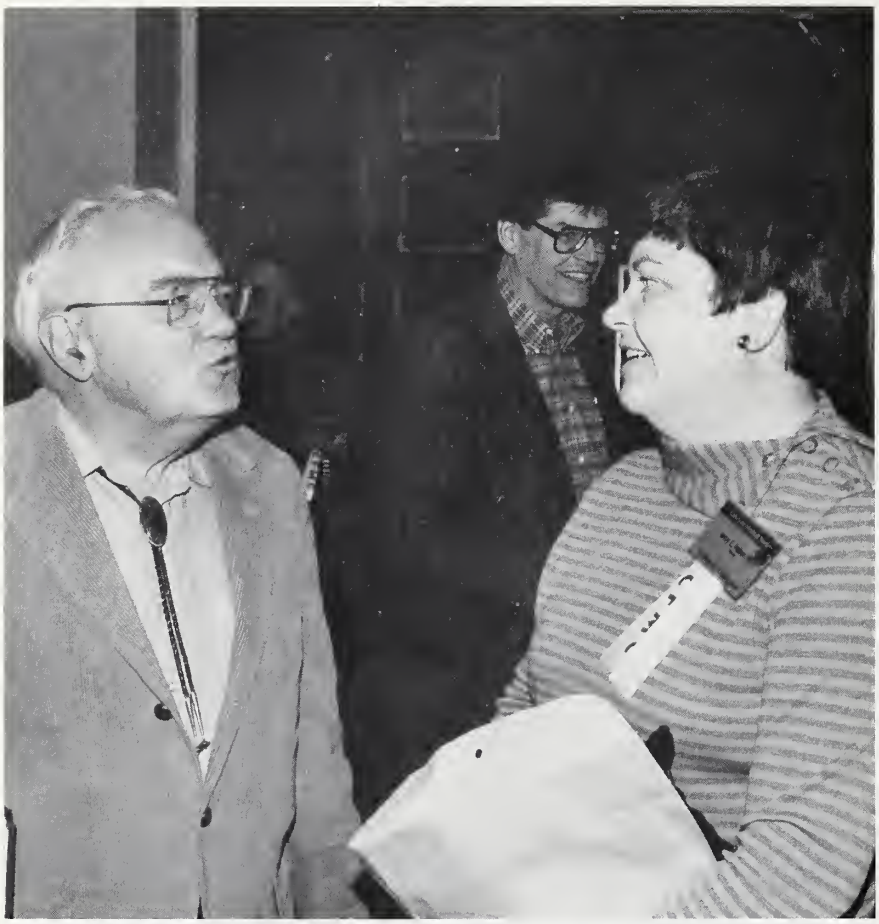
• Adopted a resolution to support safety belt use as an important public health measure and to urge Colorado state legislators to pass a mandatory seat belt law. However, concern was expressed that such legislation may be extremely difficult to enforce, that it may infringe on citizens' rights and that the cost of enforcement may exceed the benefits of such legislation (HB/Res-3).

Public Health

• Approved the progress report and additional reports (Medications in Schools, Indoor Air Pollution and Update on Denver's Brown Cloud) of the Council on Public Health, with recommendations that 1) Council on Public Health be reminded that the original amphetamine resolution included other sympathomimetic amine drugs; 2) It be pointed out to the Committee on Environment that the pollution problem is not limited to Denver; 3) that the council continue to consider including lay midwives, public health groups in dialogue; 4) the Committee on Medical Aspects of Sports develop policies for the use of protective motorcycle headgear; that the Committee on Health Education and School Health recommend to the State Board of Health revision of









"Standards and Regulations - Medications in Schools."

• Adopted an amended resolution to encourage non-smoking measures. Amendments are to encourage Colorado cities and counties to provide non-smoking seating areas in public facilities; develop CMS anti-smoking stickers (LM/Res-9).

• Adopted an amended resolution that CMS provide information to the public on the risks of home birth and on safe alternatives to home delivery (LM/Res-10).

Professional Education

• Approved the progress report and supplemental report of the Council on Professional Education.

Professional Relations and Medical Service

• Approved the progress report and supplemental report of the Council on Professional Relations and Medical Service.

• Approved amended · Addendum #1, regarding proposed new statutory language on ambulance personnel minimum training requirements.

• Adopted an amended resolution that only one physician file be encouraged for each hospital medical staff member; that any hospital file on a physican be open to him or her upon request; that physicians be advised annually by their hospitals that they should review their files and that the CMS medical staff section communicate this policy to hospitals and the hospital association (L/MS-Res-18).

• Adopted a substitute resolution that hospital administrations should seek medical staff participation in hospital decisions on marketing and advertising and that medical staffs should actively seek such participation (L/MS-Res-19-A).

• Adopted a resolution regarding hospital medical staff reappointments and renewal of staff privileges; that utilization of hospital resources by staff should be considered only in conjunction with professional performance and in staff's role as patient advocate (L/MS-Res-20).

• Adopted an amended resolution that hospital medical staffs should adopt the policy that they have sole authority "to select and remove their own officers, set standards for medical staff/patient care and recommend clinical privileges" and to incorporate this policy into model hospital medical staff bylaws. The resolution further states that CMS representatives to the AMA incorporate these philosophies into Joint Committee on the Accreditation of Hospital guidelines (L/MS-Res-21).

• Adopted an amended resolution that CMS should encourage hospital medical staffs to secure their own legal counsel "separate and apart from the hospital administration" and that prior to the 1984 Annual Meeting, the CMS Board of Directors investigate the "fiscal impact of having CMS, through our legal counsel, offer this as a service to our membership" (L/MS-Res-22).

Socio-Economics

• Approved the progress report of the Council on Socio-Economics and additional reports (report of Colorado Task Force on the Medically Indigent; Colorado Health Forum report; Medicaid White Paper; V.E. Policy Statement). Commended the reports of the task force and the health forum and recommended that they be read by all CMS members. Encouraged continued study of the problems outlined in these reports.

• Adopted a resolution that CMS "take whatever steps are necessary" to facilitate the discharge of patients from hospitals to nursing homes on Saturdays or Sundays" (L/Res-8).

Foundation

• Approved the progress report of the Colorado Foundation for Medical Care.






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AGES

Delegate Attendance — 1984 Interim Meeting

District I — 19 Delegates

Larimer — 8 Delegates

(D)	Elo, Denis R.	(1,2)
(D)	Miller, Burdette L.	(1,2)
(A)	Wera, Thomas	(2)
(D)	Standard, Peter J.	(1,2)
(D)	Thorson, Steven J.	(1,2)
(D)	Kasenberg, Thomas	(1,2)
(D)	Merkel, Lawrence A.	(1,2)
(D)	Preble, Parker	(1,2)

Morgan — 1 Delegate

(D)	Thompson, Patrick L.	(1,2)

Northeast Colorado — 2 Delegates

(D)	Beard, Charles	(1,2)
* (A)	Ollhoff, Harold J.	(1,2)

Washington-Yuma — 1 Delegate

None Present

Weld — 7 Delegates

(D)	Cash, Robert L.	(1,2)
(D)	Hartley, Robert D.	(1,2)
(D)	Kahn, Robert J.	(1,2)
(D)	Baldwin, Thomas E.	(1,2)
(A)	Cullen, John P.	(1)
(D)	Clark, Ronald D.	(2)
(D)	Hutchins, Earl C.	(1,2)

District II — 121 Delegates

Aurora-Adams County — 10 Delegates

* (A)	Buckley, Jerome M.	(1,2)
(A)	Soler, Joseph J.	(1,2)
(D)	Kitlowski, Noel P.	(1,2)
* (A)	Wick, James E.	(1)
(D)	Sherman, M. Eugene	(2)
(D)	Delaney, James J.	(1,2)
* (A)	Rokicki, Robert	(2)
(D)	Hopple, Lynwood M.	(1,2)
(D)	Imatani, Raymond J.	(2)
(A)	Tyburczy, Joseph A.	(1,2)

Arapahoe — 16 Delegates

(D)	Bartlett, Max	(1,2)
(A)	Heiss, Robert E.	(1,2)
(D)	Freed, John H.	(1,2)
(A)	Robertson, John L.	(1,2)
(D)	O'Neill, Eugene T.	(1,2)
(D)	Sargent, Frank T.	(1,2)
(D)	Spalter, Roger M.	(1,2)
(D)	Faul, John C.	(1,2)
(A)	Bartee, Roy M.	(1,2)
(D)	Kreye, George M.	(1,2)
(A)	Seegers, Winifred	(2)
(D)	Steines, William	(1,2)

Boulder — 11 Delegates

(D)	Benson, Alan E.	(1,2)
(A)	Bolles, Gene E.	(1,2)
(D)	Hickman, Gerald M.	(1,2)
(D)	Rubright, Mark W.	(1,2)
(D)	Smith, Darvin, W.	(2)
(D)	Stein, Donald W.	(1,2)
(D)	Bedell, Richard F.	(1,2)
(D)	Firestone, Marvin H.	(1,2)
(D)	Kelley, Severance B.	(1,2)

Clear Creek Valley — 20 Delegates

(D)	Campbell, Bernard E.	(1,2)
(D)	Doig, William	(1,2)
(D)	Dorr, Lugene	(1,2)
(A)	Siegel, Gary L.	(1)
(D)	Erben, Ivo	(2)
(D)	Golbert, Thomas	(1,2)
(A)	Furman, F. Joseph	(1,2)
(A)	Payea, Norman	(1,2)
(D)	Tegtmeier, Ronald E.	(1,2)
(D)	Underwood, Larry	(1,2)
(D)	Yakely, M. Robert	(1,2)
(D)	Berg, Dal A.	(1,2)
(D)	Brundige, Richard L.	(1,2)
(A)	Tarkanian, Malcolm M.	(1)
(D)	Cedars, Chester	(2)
(D)	Doyle, Herman	(1,2)
(D)	Netz, Howard E.	(1,2)
(D)	Oppenheim, Walter H.	(1,2)
(D)	Potts, William E.	(1,2)
(A)	Roark, Michael F.	(1,2)
(D)	Silverberg, Stuart O.	(1,2)
(A)	Laubach, Sherri	(1,2)

Denver — 60 Delegates

(D)	Bailey, William C.	(1,2)
(D)	Bennett, Willis L.	(1,2)
(D)	Blaney, Loren F.	(1,2)
(D)	Boswick, John A., Jr.	(1,2)
(D)	Bramley, Howard F.	(1,2)
(D)	Butterfield. L. Joseph	(1,2)
(D)	Campbell, William A., III	(1,2)
(D)	Chilcoat, Donald L.	(1,2)
(D)	Cook, William R.	(1,2)
(D)	Fink, Donald W.	(1,2)
(A)	Murphy, Daniel	(2)
(D)	Holt, Steven A.	(1,2)
(D)	Humphries, Jess	(1,2)
* (A)	Klapper, Jack A.	(1,2)
(A)	Cole, Toby P.	(1,2)
(D)	Lacher, John W.	(2)
* (A)	Woodard, W. Donald	(1,2)
(D)	Nelson, Nancy E.	(1,2)
(D)	Newman, Thomas H.	(2)
(D)	Parsons, Donald W.	(1,2)
(D)	Peck, Mordant E.	(1,2)
(D)	Philpott, Osgoode S., Jr.	(1,2)
(D)	Ping, Donald W.	(1,2)
(A)	Mueller, John F.	(1,2)
(D)	Rhodes, Edward A.	(1,2)
(D)	Sides, LeRoy J.	(1,2)
(A)	Angello, Anthony L.	(1,2)
(D)	Stanfield, Clyde	(1,2)
(D)	Sullivan, Robert C.	(1,2)
(D)	Toll, Giles D.	(2)
(A)	Zbylski, Joseph	(1,2)
(D)	Appelbaum, Jerry	(1,2)
(D)	Ballonoff, Larry B.	(1,2)
(D)	Butterfield, Donald G.	(1,2)
(D)	Carlson, H. Blair	(1,2)
(D)	Chisholm, John W.	(1,2)
(D)	Curry, Marcia F.	(1,2)
(A)	Howe, Patrick A.	(2)
(D)	Flax, Leo J.	(1,2)
(A)	Walker, Louise D.	(2)
(D)	Holman, Richard E.	(1,2)
(D)	Inkret, William, Jr.	(1,2)
(D)	Kelble, David L.	(1,2)
(D)	Kosmicki, Patrick W.	(1,2)
(D)	Lightburn, John L.	(1,2)
(D)	Livingston, Wallace H.	(1,2)
(D)	McCurdy, Robert E.	(1,2)
(D)	Muftic, Michael	(1,2)
(D)	Nelson, J. Phillip	(1,2)
(D)	Schemmel, Janet	(1,2)
(D)	Sigdestad, Joel B.	(1,2)
(D)	Smyth, Charley J.	(1,2)
(D)	Urwiller, Richard D.	(1,2)

University of Colorado — 4 Delegates

(A)	Shonk, John J.	(1,2)
(A)	Corliss, Scott A.	(2)
(D)	Ardell, Lynda K.	(1,2)
* (A)	Salazar, Maryruth	(1,2)

District III — 21 Delegates

El Paso — 18 Delegates

(A)	Spaulding, Duane R.	(1,2)
(D)	Cooper, Jack	(1,2)
(D)	Cunningham, Leon D.	(1,2)
(A)	Gatchell, H. Dale	(1,2)
(D)	Kandel, George E.	(1,2)
(D)	Martz, David C.	(1,2)
(D)	Miller, Floyd J.	(1,2)
(D)	Nathan, Robert A.	(1,2)
(A)	Pick, Melvin M.	(1,2)
(D)	Bengfort, John L.	(1,2)
(D)	Burton, Richard M.	(1,2)
(D)	Crawford, Lewis A.	(1,2)
(D)	Dawson, Dwight C.	(1,2)
(D)	Genrich, John H.	(1,2)
(A)	Muth, John B.	(1,2)

Intermountain — 1 Delegate

(D)	Sophocles, Aris	(2)

Lake — 1 Delegate

None Present

District IV — 19 Delegates

Chaffee — 1 Delegate

None Present

Fremont — 2 Delegates

(D)	Bruffy, James	(1,2)
(D)	Gamache, Peter J.	(1,2)

Huerfano — 1 Delegate

None Present

Las Animas — 1 Delegate

(D)	McFarland, Douglas M.	(1,2)

Otero — 2 Delegates

(D)	Baumgartner, Robert B.	(1,2)

Pueblo — 9 Delegates

(D)	Boucher, Wesley	(1,2)
(D)	Crosson, David L.	(1,2)
(D)	Phelps, Harvey W.	(1,2)
(D)	Reichert, Thomas K.	(1,2)
(D)	Bedard Charles	(1,2)
(D)	Dingle, Robert W.	(1,2)
(A)	Smith, Christopher J.	(1,2)
(D)	Reilly, Gerald D.	(1,2)

San Luis Valley — 2 Delegates

(D)	MacLeod, William A. J.	(1,2)
(D)	Schmidt, Edwin W.	(1,2)

Southeastern Colorado — 1 Delegate

(D)	Bermingham, Roger P.	(1,2)

District V — 18 Delegates

Delta — 1 Delegate

None Present

La Plata — 3 Delegates

(D)	Davis, Telford A.	(1,2)
(A)	Butler, Harrison G., III	(1,2)

Mesa — 6 Delegates

(D)	Hartshorn, Denzel F.	(1,2)
(D)	Huskey, Harlan B.	(1,2)
(D)	Moran, Patrick G.	(1,2)
(D)	Phillips, Michael S.	(1,2)

Montelores — 1 Delegate

None Present

Curecanti — 2 Delegates

(D)	Canfield, Thomas M.	(1,2)

Mount Sopris — 3 Delegates

(D)	Jacobs, Mary Jo	(1,2)

Northwestern Colorado — 2 Delegates

(D)	France, David W.	(1,2)

* (A) Substitute Alternate appointed to fill a vacant seat

1 Attended first meeting of the House of Delegates

2 Attended second meeting of the House of Delegates



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Questions and Answers on the "Baby Doe" Rulings

by Michael Victoroff, MD

Ed. Note: Dr. Victoroff is an active medical ethicist and frequently lectures to both physicians and other health care practitioners as well as to civic groups, schools and other groups on medical ethics. He belongs to several ethics committees and is chairman of the ethics committee of the Perinatal Care Council. Dr. Victoroff is a family practitioner and Associate Clinical Professor in Family Practice at the University of Colorado Medical School.

What does the law provide?

First of all, the "Baby Doe Role" is not precisely a "law." It is a set of administrative guidelines relating to nondiscrimination on the basis of handicap, for infants needing medical care. Under section 504 of the Rehabilitation Act of 1973, the federal government may withhold financial assistance from programs which discriminate against handicapped persons. Although the act applies to persons of any age, and was intended to protect the interests of handicapped individuals in commerce, industry and schools, the current interpretation of the Department of Health and Human Services would apply the law to the situation of withholding medical treatment from defective newborns.

What is "discrimination"?

Under the meaning of the rules, "discrimination" would be the withholding of a medically-beneficial treatment from a newborn solely because the child has a handicap. For example, we treat strep throat whether or not a patient is blind. We treat a broken leg whether or not a patient is deaf. The rules specifically address the issue of denying potentially curative, life-saving or otherwise clearly beneficial treatments to mentally retarded or crippled (e.g. Down's Syndrome and spina bifida) children. They require that any treatment, including feeding, which offers medical benefits must be provided, regardless of the parent's wishes or the expected quality of life of the patient.

The rules treat the withholding of clearly beneficial care . . . as medical neglect

What is a "handicap"?

By the definition in the rules, a handicapped person is, "Any person who has a physical or mental impairment which substantially limits one or more of such person's major life activities . . . or (iii) is regarded as having such an impairment."

Obviously, this definition is extremely imprecise, from a philosophical standpoint, and painfully inadequate for making important medical judgments. Although it can be seen how this might apply to certain newborns who have "impairments" analogous to those of disabled adults, there are many medical conditions of newborns which have no true counterparts in adult life; fetal anomalies, for example. To pursue the definition to its logical extreme, the state of normal infancy is one in which physical and mental constraints limit life activities. Is childhood an "impairment", then, in the sense of the rules? And what about conditions which are clearly "illnesses"? Are these also impairments, or are some of them? Is Trisomy 13 a handicap or an illness, and does it matter? Lack of clear answers to these relevant, philosophical questions is an impairment of the rules.

Does this rule imply that every ill newborn must be saved?

On the face of the rule itself, one might think so. But the voluminous explanatory material which accompanies the rule expressly denies this. In fact, the rule gives several examples of cases which do not require treatment; for example, anencephaly. Treatments which are clearly "futile, hopeless or impossible" are not required. Treatments which merely "prolong the process of dying" are not required. Certainly, nothing in the rules changes current practices in the diagnosis of death, or in the withdrawing of support systems from those already dead, or from the "permanently unconscious."

The principal novelty of the rules — and their explicit intention — is to treat the withholding of clearly beneficial care from viable, promising, retarded infants as cases of medical neglect.

Don't the rules violate the parent's right to make decisions for their children?

The rules limit parental rights, truly. But there is nothing either new, or ethically offensive in this per se. Our society acknowledges many restraints on parental descretion regarding children. Conventional child abuse and neglect laws, child labor laws and statutes covering topics from drivers' licenses to homicide, limit parents' freedom to treat children as property. Until now, not only federal law, but many state jurisdictions were silent or unclear about the boundary between well-intentioned decisions to forego treatment and intentional or unintentional negligence. Children of Jehovah's Witnesses have provided numerous cases for the testing of society's norms in this respect. Consensus seems to favor the children's medical welfare over the parents' religious freedom. The Doe Rule expresses essentially the same ethical view in a more sweeping manner.

What are the penalties for "discrimination" against a handicapped child?

There seem to be at least six possible ways to get into trouble. The first, of course, is prescribed by the rules themselves: namely, to jeopardize an institution's federal funding. However, this seems to occur, not upon a single instance of civil rights violation, but only if there is a clear policy of discrimination. Defense for the institution simply might be to prove that a given case of discrimination was isolated and not evidence of a systematic policy. Even if a policy of discrimination was shown, all the hospital would need to do would be to rectify it and federal funds probably would be resumed. The lengthy appeals process, in this case, would seem to protect a well-intentioned institution from much chance of serious risk.

The second legal risk is much clearer. The rules ask that the state child protective agency investigate "Doe" cases as potential child abuse. If a physician were found to be an accessory to this charge, Colorado provides felony penalties. A defense would turn on the issues of standard of care and a jury's tendency to be sympathetic to medical acts which are truly aimed at the patient's benefit. How a contemporary jury would view a particular case of withholding care would be largely influenced by the opinions of medical expert witnesses.

The third risk is a familiar one. We are all aware of the legal requirement to report suspected cases of child abuse. Failure is a legal misdemeanor. Until a precise understanding is reached of what cases actually fall under the Doe Rules, it would seem incumbent upon nurseries to keep in close touch with local social services personnel about any case which may qualify. Naturally many questions of confidentiality are raised, but the Children's Code clearly protects good faith reporters. The chief detriment will be to the doctor-patient relationship.

The fourth risk is probably very remote, but a theoretical concern. If a physician were to be found responsible for violating a child's civil rights, he or she could be liable for damages resulting from this as well as other federal penalties. Since malpractice insurance would provide no protection from resulting liabilities, such a judgment would be ruinous. However, legal opinion is generally that individual physicians would be unlikely targets for prosecution of this kind.

The fifth risk is simply medical malpractice. This would be defended as in the second case above. Isn't it refreshing to find something familiar?

The sixth legal risk is so remote as to be bizarre. This is the possibility that a defective child might bring a "wrongful life" suit, in the event that it was saved by aggressive treatment, in a condition that it felt to be "worse than death." This is the ultimate medical "Catch-22" and is so perverse that it should be discounted in any state except California.

The rules do not address resources demanded by severely defective survivors.

Doesn't anything stand between the doctor and these legal threats?

Fortunately, the latest version of the rules suggests a valuable approach, which may solve many controversies: the Infant Care Review Committee (ICRC). Thus the rules formally recognize the value of hospital and other institutional ethics committees. Furthermore, the Colorado Department of Social Services has shown a great degree of sympathy to the problems of investigating Doe cases and will undoubtedly be doctors' strongest ally in keeping things rational.

As always, in situations in which medical treatment is an issue, the physician's first and last resort is to his or her colleagues, whose professional opinions form the standard by which care is judged.

What can hospitals, which do not have the resources to form an ICRC, do?

Don't despair. Several options, besides transferring an infant, are available. County departments of social services may request a consultation from a neonatologist. The hospital may ask for a formal, voluntary review from another institution's ICRC. Or a hospital may ask the Perinatal Care Council for consultation or referral.

What liabilities do ICRC members face?

Who knows? In spite of multiple appeals to the Colorado Department of Health, the regional civil rights office and many consultations with social services, no definite opinion can be found. A letter asking this question is in the hands of the federal OCR. Attempts continue to obtain an opinion from the state attorney general. Since the responsibility of an ICRC is strictly advisory, it may be that liability is limited. However, since a physician could argue that such a committee's decision is compelling, there might be some liability exposure.

Do the Doe Rules say what happens to the "tragic survivors" of federally mandated medical treatments?

No. There is nothing in the rules which addresses the possible increased resources demanded by severely defective children who would have died without treatment. While it seems ironic for a government which is so concerned about the interests of infants to neglect the care of certain other classes of persons, there is nothing to logically compel the government to provide care which it feels is morally required of parents. Furthermore, the expense of a patient's care is not sufficient reason to withhold treatment, absent other, far more compelling considerations. Euthanasia emphatically is not an answer to resource problems.

Doesn't the possible penalty of closing a neonatal ICU threaten to punish many innocent children for the sake of protecting one child's civil rights?

Yes. Obviously, the financial penalty was the only one available to federal authorities, under the Rehabilitation Act. This strategy is dubious; to achieve non-discrimination, it imposes a threat of a greater wrong.

The "Baby Doe" Issue: Developments at the State Level

by John R. Britton, MD, Ph.D.

Ed. Note: Dr. Britton is an assistant professor at the Department of Pediatrics, Perinatal and Nutritional Sciences Section, University of Arizona Health Sciences Center, Tucson. This article, which has been revised and updated by the author for Colorado Medicine, was originally published in the Western Journal of Medicine.

The dilemma of withholding treatment from defective newborns has faced the medical and legal professions for more than a decade, but it is only within the last year that national attention has been focused upon this issue by regulations of the Department of Health and Human Services. These regulations, known as the "Baby Doe" rulings, have generated a vast debate, pitting right-to-life groups against medical professional organizations and leading to litigation on a number of occasions. Three sets of regulations have been issued by the department on this issue, the most recent of which became effective on February 13 of this year.[1-3] The history of the controversy surrounding the regulations has been adequately summarized elsewhere[4,5] and will not be elaborated upon here. It is the intent of this article to focus upon developments at the state level which have addressed the "Baby Doe" issue. Although these developments have gained relatively little attention, they may achieve increasing importance in light of recent national legislation which proposes to delegate to the individual states responsibility for setting guidelines regarding the care of handicapped infants.

Several states, including Louisiana, Indiana and Arizona have enacted legislation addressing the issue of non-treatment of defective newborns.[6,8] Although these states are currently the only ones which have passed laws, a number of others are considering similar legislative enactments. Legislation in Arizona is among the most recent and exemplary; consequently it will be discussed in detail in this article.

On April 27, 1983 Arizona House Bill 2209 was signed into law by Governor Bruce Rabbitt.[8] The bill is part of an amendment to the state's child abuse reporting statute, and it explicitly requires that "a person shall not deny or deprive a newborn child of food, nutrients, water or oxygen with the intent to cause or allow the death of the child for any reason." The bill specifically emphasizes that such denial should not be based upon the presence of a "handicap which, in the opinion of the parent or parents of the child, the physician or another person, diminishes the quality of the child's life."

Deprivation of necessary life-saving medical treatment or surgical care of a minor child is also prohibited by this legislation, although a clause does permit refusal of consent to medical or surgical treatment which is not necessary to save the life of the child or which carries potential risks outweighing potential benefits. The bill states that facilities with perinatal, obstetrical or pediatric units are required to inform their employees of their duty to report any denial or deprivation of care or nourishment of the Child Protective Services program of the Department of Economic Security of the state. Such reports may be made by any individual suspecting that deprivation of care or nourishment was undertaken with the intent to "cause or allow the death of the child" and are to be made in the same manner as those for child abuse. Failure to report denial of treatment is equated with failure to report child abuse, a class II misdemeanor in the state of Arizona, which carries a possible four-month prison sentence.

Although the bill was signed in April, 1983, lobbying by the Arizona Medical Association was successful in postponing the effective date until July 1, 1984. The purpose of this delay, presumably, was to permit time for extended dialogue between medical groups and the legislature and for appropriate revision of the bill if deemed necessary. Indeed, the Arizona Medical Association did present a proposed revision to the state legislature which was based primarily upon the recommendations of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.[9] Central to the medical association's original proposal was the establishment of mandatory infant bioethical review committees which were to provide a framework for decision making within which the patient's interests were foremost and which acknowledged the rights of the parent or guardian as the primary decision maker.

The committees were also proposed to play an advisory role in decisions to withhold treatment and to recommend institutional policies concerning such decisions. A mechanism for retrospective review of medical records of those infants for whom treatment had been withheld or withdrawn was included. Of note was a stipulation that in cases where the parent refuses to consent to life-sustaining care but the infant bioethical review committee recommends treatment, the committee would recommend immediate referral to the Child Protective Services Agency, which would then take appropriate action.

An amendment did emerge from negotiations between the Arizona Medical Association and the legislators in the form of House Bill 2457, which was proposed by the same representative who had introduced the original bill. Bill 2457 has passed the Arizona House of Representa-

tives and on March 8, 1984 was sent to the Arizona Senate, where it is presently under consideration.[10] The bill is similar to House Bill 2209 in that it proscribes the withholding of "medically beneficial treatment or surgical care or nourishment" with the intent to cause or allow the death of a handicapped infant. It requires health care providers to report any incident of alleged deprivation of care to a municipal or county peace officer or the Child Protective Services program of the Department of Economic Security. Unlike House Bill 2209, the new bill encourages hospitals to establish infant care review committees "to assist the institutions in delivering health care and related services to infants"; however, such committees are neither mandated nor specifically assigned a major role in the decision-making process.

The Arizona legislation is somewhat vague in that "medically beneficial treatment" and "surgical care" are not defined. The original bill requires treatment of all defective infants; the only exceptions are those cases in which therapy is not required to save life or poses a greater risk than that of the defect itself. The pending amendment would not prevent an infant's parents or guardian from refusing to consent to treatment which "is not medically beneficial, including care or treatment which... will do no more than temporarily prolong the act of dying of a terminally ill infant." It further states that "In determining whether any of the possible medical treatments will be medically beneficial to an infant, reasonable medical judgements in selecting among alternative courses of treatment shall be respected." In its current form, Arizona's HR 2457 is quite similar to the latest regulations of the Department of Health and Human Services.[3]

It is important to realize that legislation such as that enacted in Arizona and pending or in force in other states may be supported by legislation currently under consideration at the national level. On February 2, the U.S. House of Representatives passed House Bill 1904 against the opposition of many medical professional groups, including the American Academy of Pediatrics, by a 231-182 vote.[11] The bill has gone on to the U.S. Senate for consideration. HR 1904 is a proposed revision of the Child Abuse Prevention and Treatment Act and the Child Abuse Prevention Treatment and Adoption Reform Act of 1978. It assigns to the states the discretion to act "to insure the nutrition (including fluid maintenance), medically-indicated treatment, general care and appropriate social services are provided to infants at risk with life-threatening congenital impairments."

The bill requires that the states establish procedures "to be followed by child protective service agencies or individuals as a state may deem appropriate, social service providers and courts of competent jurisdiction" to achieve these ends. The bill proposes that the Department of Health and Human Services provide assistance in this endeavor. However, it is not explicit about the nature of procedures so established, nor does it provide for any check upon the resulting mechanisms. Failure to establish procedures may result in loss of federal funding to state child abuse agencies. Of note is that HR 1904 encourages but does not mandate the institution of ethical review boards. If this bill becomes law then legislation such as that passed in Arizona and other states could be sustained. Moreover, it is conceivable that different states might pass laws which differ substantially from one another, leading to significant variability in the standard of care from state to state.

It is evident from both the U.S.

AMA Sues HHS on Baby Doe Regulations

The American Medical Association filed suit in late March against Health and Human Services Secretary Margaret Heckler seeking to have the "Baby Doe" regulations declared invalid. The suit contends that the regulations improperly interject the HHS Office for Civil Rights into treatment decisions concerning seriously ill newborns; that the regulations are beyond the statutory authority of the Rehabilitation Act; that in promulgating the regulations Secretary Heckler failed to conduct an adequate factual investigation or respond to significant comments or proposals; and that parental constitutional rights are violated by the regulations.

The suit asserts that federal rules permitting such investigations were "held unlawful" by the 2nd U.S. Circuit Court of Appeals when it denied the government access to "Baby Jane Doe's" records on February 23. (The Reagan administration has asked a federal appeals court to reconsider a ruling that barred it from investigating the hospital treatment of "Baby Doe", who was born six months ago with an open spinal column and an abnormally developed head.)

Her parents opposed corrective surgery, and the federal government sued University Hospital in Stony Brook, New York, in an unsuccessful attempt to subpoena her medical records for a civil rights investigation.

The AMA lawsuit was filed in New York, where any appeal would go to the same court that decided the "Baby Doe" case.

Joining the AMA in the suit are the American Hospital Association, the Hospital Association of New York State, the American College of Obstetricians and Gynecologists, the Association of American Medical Colleges, the American Academy of Family Physicians, two obstetricians and two neonatalogists.

The suit occurs as the Reagan administration pursues efforts to investigate whether handicapped infants suffer discrimination as a result of medical decisions denying them life-prolonging treatment.

Dr. James H. Sammons, executive vice president of the AMA, said, "The AMA believes without reservation that medical decisions involving the care of severely handicapped newborns should be the responsibility of the parents in consultation with their physicians and other professionals on the medical treatment team."

House of Representatives bill and the legislation in Arizona that the current trend is to include denial of care for handicapped newborns in the definition of child abuse, a principle which has met with sharp opposition from the American Academy of Pediatrics.[12] Although recent legislative and executive rulings favor the establishment of ethical review committees, none has mandated their formation. Also, most rulings have advocated a reporting mechanism whereby alleged instances of withholding of care of defective newborns may be called to the attention of the government authorities. The potential still exists for repeated investigations similar to those which have occurred during the past year under previous "Baby Doe" regulations in response to calls received on the "Infant Doe hotline." That such investigations may be intrusive and potentially detrimental to the well-being of infants and families has been suggested by several case reports.[13]

Considerable confusion has also been generated by the number and nature of rulings at different governmental levels. For example, the Department of Health and Human Services believes that its latest set of regulations is adequate and that legislation is unnecessary.[12] The department continues to base these regulations upon its interpretation of Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of handicap within any program receiving federal financial assistance. Nevertheless, in addition to HR 1904 and the legislation in the various states, there is also a bill pending before the U.S. Senate (SB 1003) which advocates the formation of a multidisciplinary advisory board which would "make recommendations concerning appropriate procedural mechanisms to be utilized by health care facilities" in the care of handicapped infants.[14] This bill favors legislation at the national level and would not delegate responsibility for these decisions to the states. Considering the multiplicity of levels upon which laws are being proposed, it is difficult to discern which rulings would take precedence; this may become an issue for the courts eventually to decide.

The "Baby Doe" issue obviously is far from being resolved and a number of questions, both legal and ethical, remain. Among the latter are the cost implications of current rulings for society, both for monetary funding and health care resources. Foremost, of course, is the best interest of the individual infant, but it remains to be established whether current or pending rulings will in fact ensure that interest.

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14. Ninety-eighth Congress, S. 1003.

Acknowledgment

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obituaries

Stuart G. Dunlop, Ph.D., an honorary member of the Denver Medical Society, died February 23 in University Hospital after a long illness. He was 76.

Dr. Dunlop was born November 19, 1907 in Chicago. He married Dorothea Greene March 15, 1941 in Chicago.

He was in the Officers' Reserve Corps of the U.S. Army from 1942 to 1946, serving in Chicago. He was officer in charge of bacteriology, food chemistry and vitamin assay laboratory.

Dr. Dunlop received undergraduate degrees in pharmaceutical chemistry from the University of Illinois in 1928 and in pharmacy from the University of Colorado in 1938. He received his doctorate in bacteriology from the University of Colorado School of Medicine in 1947.

He was hired as an instructor at CU's School of Medicine in 1947. He was appointed to a professorship at the school's Department of Microbiology/ Immunology in 1964. He retired July 1, 1976.

He stayed active as professor emeritus in the medical school.

Dr. Dunlop served as a consultant in microbiology at the Fitzsimons Army Hospital, University Hospital, Colorado Psychopathic Hospital and the Denver Water Board.

He was elected to honorary membership in DMS in 1979.

Surviving, in addition to his wife, are two sons, Robert Dunlop of Aspen and Dennis Dunlop of Denver.

Marshall Grant Nims, MD, of the Denver Medical Society, died April 2 in Tucson, Arizona. He was 75.

Dr. Nims was born July 11, 1908 in Bronxville, New York. He married Mary E. Naugle on August 23, 1933 in Sterling, Colorado.



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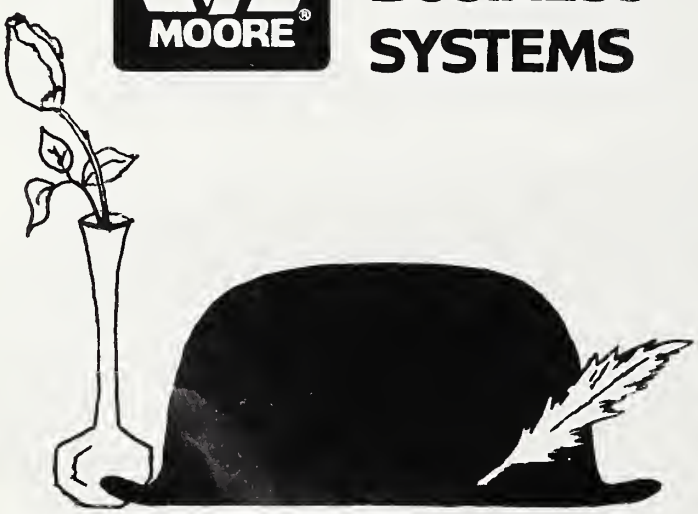
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After serving as an intern at Harper Hospital in Detroit and as house physician at Bellevue Hospital in New York City, he started practice in Denver 1939. He was an attending physician at Denver General Hospital and on the staff of Saint Luke's Hospital. He specialized in internal medicine and cardiology.

Dr. Nims served in the army from 1942 to 1945, leaving with the rank of major.

He received the Colorado Heart Association Humanitarian Award in 1978 and the Distinguished Service Award in 1984 from the Colorado Chapter of the American College of Physicians and Colorado Society of Internal Medicine.

Surviving in addition to his wife, are a daughter, Barbara Weiss of Laguna Niguel, California; two sons, Peter Nims and Christopher Nims, both of Denver, and six grandchildren.

Kenneth Ray Gottesfeld, MD, of the Denver Medical Society, died February 1 in a skiing accident at Copper Mountain, Colorado. He was 45.

Dr. Gottesfeld was born August 21, 1938 in Denver.

He graduated from East High School in 1955 and received a bachelor's degree from Amherst College, Massachusetts, in 1958. He received his medical degree from the University of Colorado in 1962.

He interned at Mount Sinai Hospital, New York, from 1962 to 1963. Dr. Gottesfeld did his residency at the University of Colorado Health Sciences Center from 1963 to 1967.

He was a major in the Army Medical Corps at Beaumont General Hospital in El Paso, Texas from 1967 to 1969.

He married Joan Sollfrey on October 1, 1969 in Denver.

Dr. Gottesfeld, recognized by his peers as one of the leading obstetricians in Denver, was a nationally-recognized authority on ultrasound.

Surviving, in addition to his wife, are two daughters, Dana Lynn Gottesfeld and Lisa Kay Gottesfeld; his mother, Marion G. Gottesfeld; two brothers, Stuart A. Gottesfeld, MD, and Ray L. Gottesfeld, MD; and a sister, Phyllis Knight, all of Denver.

Continuing Medical Education

CALENDAR

Published Jointly by the Colorado Medical Society and the Colorado Foundation for Medical Care ☐ 6825 East Tennessee, Building 2, Suite 400, Denver, Colorado 80224 ☐ Tel. (303) 321-8642 x328 ☐ Prepared Monthly by Charlene N. Montrose

May, 1984

2-6 **Mountain Medicine: 1984** — Stanford Sierra Fallen Leaf Lake, California. 24 hours credit AMA/CME Category 1. Tuition: $325 for physicians and $180 for all others. Contact Office of Continuing Medical Education, School of Medicine, TB 150, University of Callifornia at Davis, Davis, California 95616, Jane A. Johnson, (916) 752-0328.

3 **Neuropsychiatric Grand Rounds** — Pueblo, Colorado. Time: 1-3 p.m. APA approved course for Category 1 credit. Developed by Colorado State Hospital to examine the relationship of neurological and psychiatric disorders. Contact: James H. Scully, M.D., Colorado State Hospital, 1600 West 24th St., Pueblo, Colorado. Phone (303) 543-1170. Held in conference room A.

3 **New Developments in Risk Factor Modification** — Hilton Inn South, 781 East Orchard, Englewood, Colorado. Sponsored by the Colorado Heart Association. Contact: Carolyn Moll, Colorado Heart Assn., 4521 E. Virginia Ave., Denver, Colorado 80222. Phone (303) 399-3121.

4 **Third Annual Adolescent Conference: Megatrends-Adolescent Care** — Fitzsimons Army Medical Center, Aurora, Colorado. Fee: $35.00. Contact: Sandy Hoops, Conference Coordinator, University of Colorado Health Science Center, 4200 E. 9th Ave., Box B-140, Denver, Colorado 80262. Phone (303) 394-7451.

4 **Program: Northern Colorado Cardiovascular Symposium/Cardiac Arrhythmias/Current Trends in Management** — Colorado State University, Ft. Collins, Colorado. Sponsor: Cardiovascular Associates of Ft. Collins, P.C. Fee: $50 practicing physicians, $30 physicians in training, nurses and paramedical personnel. Contact: Office of Conferences and Institutes, Colorado State University, Ft. Collins, Colorado 80523. Phone (303) 491-6222.

5 **Introduction to Nuclear Cardiology** — Sheraton Inn Laguardia, Long Island, New York. Fee: $150 for physicians and $75 for residents. Contact: National Institutes of Professional Education (800) 421-8452 or (303) 449-5621.

5-8 **Fourth Annual Colorado Symposium on Emergency Care** — Durango, Colorado. Contact: Randall Schulz, M.D., Mercy Medical Arts, Suite 302, 1810 E. 3rd Ave., Durango, Colorado 81301. (303) 259-2015 or Karl Graham, R.E.M.T., Manager of Ambulance Services, Durango, Colorado 81301. (303) 247-4311 ext. 269.

7-8 **Total Management of the Acute Myocardial Infarction** — Battenfeld Auditorium, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kansas. Credit: AMA, AAFP, CNE. Fees: Physicians - $200, 1 day - $120; Nurses - $90, 1 day - $60. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kansas 66103. (913) 588-4480.

10-12 **Musculoskeletal Tumor Society Meeting** — Alameda Plaza Hotel, Wornall at Ward Parkway, Kansas City, Kansas. Credit: AMA. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kansas 66103. (913) 588-4480.

11 **Kansas Medicine: Ten Years Later** — Battenfeld Auditorium, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, Kansas 66103. (913) 588-4480.

12 **The Care of Acute Hand Injuries** — The Antlers Hotel, Colorado Springs, Colorado. CME Credit: 7 hours credit AMA Category 1,7 hours AAFP prescribed. Key note Speaker: Clifford Snyder, M.D., University of Utah. Fees: $75 for physicians, $40 for residents and all applied health professionals. Contact: Lori Guziak, Department of Medical Education, Penrose Hospital, P.O. Box 7021, Colorado Springs, Colorado 80933. (303) 630-5184.

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Nominations Due for CMS Certificate of Service and for the Annual Robins Award

The deadline for receipt of nominations for the Colorado Medical Society's Certificate of Service Award and the Annual Robins Award is **June 25, 1984.**

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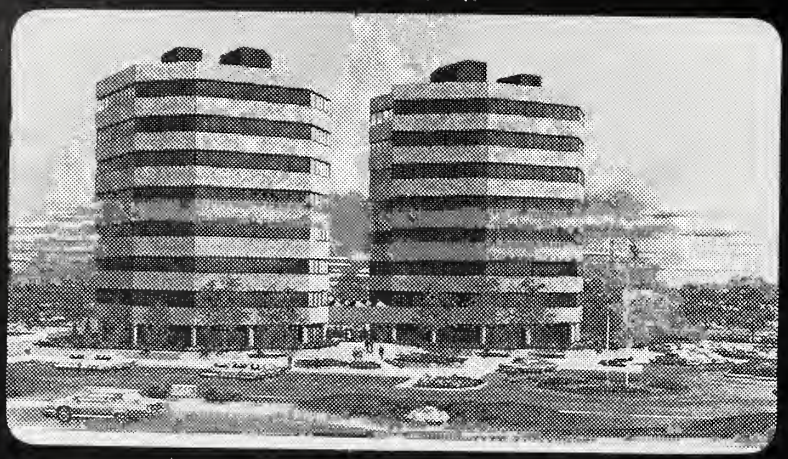
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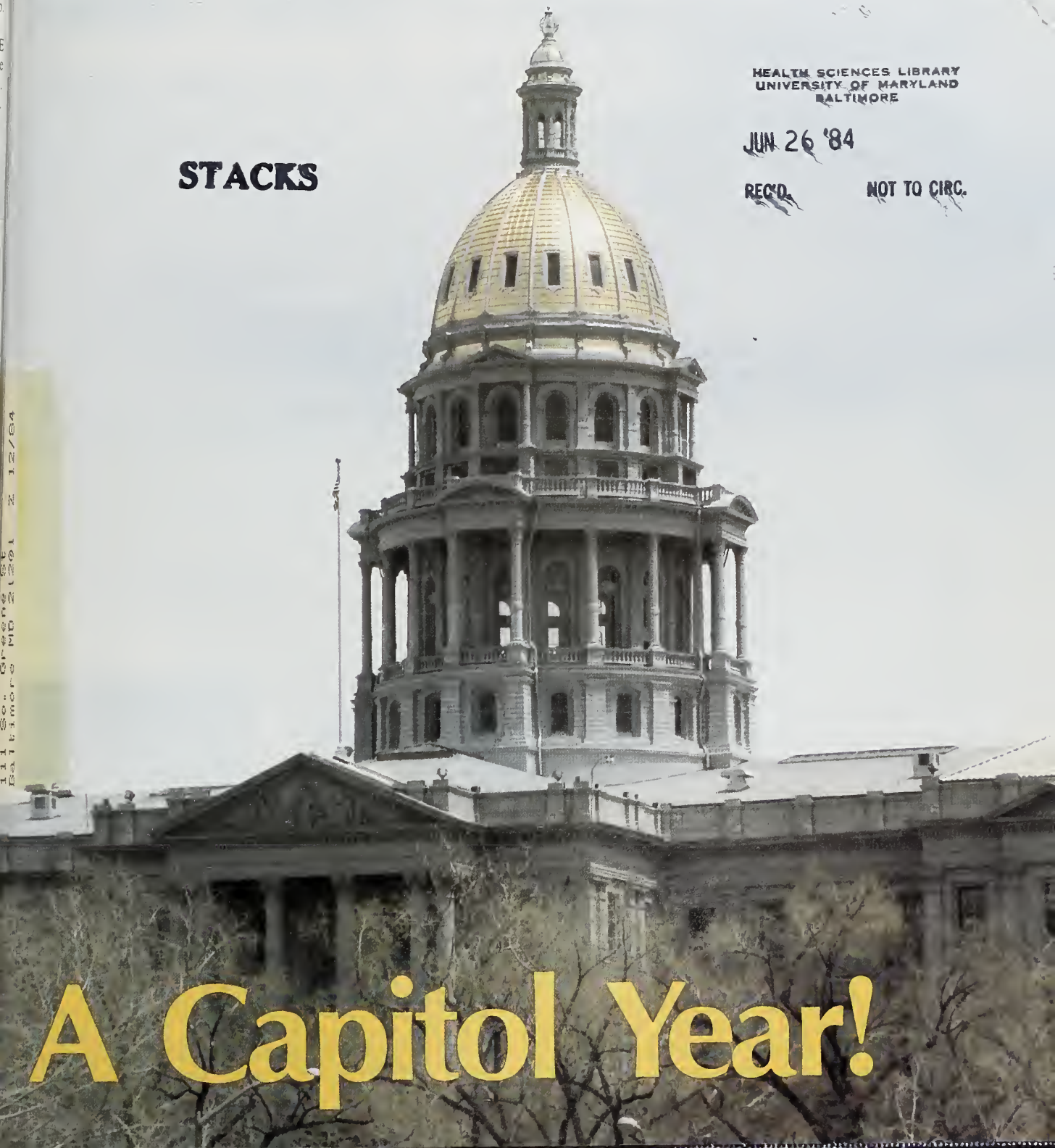
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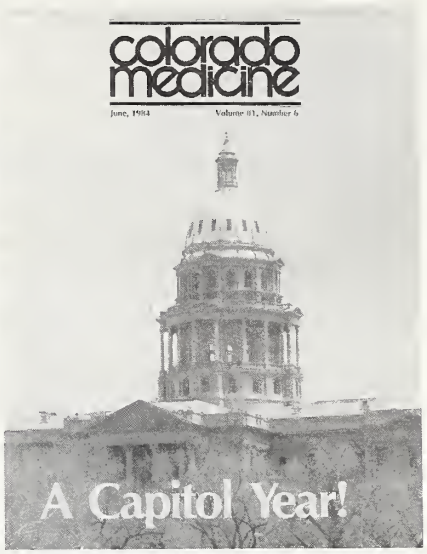



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colorado medicine



This Month's Cover:
It was a "Capitol" year for CMS in more ways than one! CMS had its most successful legislative year ever, which included winning a measure of success in the medical society's tort reform effort. The state legislature bids farewell this year to Harvey Phelps, MD, who has been in the Colorado Senate for the last eight years. Our special section on the CMS legislative effort, plus an interview with Dr. Phelps, begins on page 133.

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by Sheila Swan

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president's letter



John A. Whitesel, MD, President
Colorado Medical Society

Progress—A Continuum

The Colorado Medical Society Annual Meeting to be held in Vail this year will develop a theme revolving around the changes we are experiencing in medicine today. The theme, entitled "Changing the Face of Medical Practice," reflects tradition as well as change. Clyde Stanfield, long-time DMS and CMS member, authored a commemorative article with a similar title for the CMS centennial in 1971 which envisioned many of the changes that are presently taking place. Physicians have seen rapid changes in technology, practice association and the financing of health care during the past few years. In addition, there have also been revolutionary ideas and regulatory changes in the health care delivery system which will cause reevaluation of our medical concepts and practice. With the many alterations we are seeing in our medical practices, organized medicine is also experiencing questions, reevaluation and changes.

In our professional organizations, we are presently reviewing structure, function and benefits. Questions of justification are being asked and new approaches are being asked on many issues. This is appropriate, but we must evaluate each change, new relationship or structure as to whether it improves our present situation.

Your national, state and local medical societies have served you well in the past by working together to develop standards of medical practice, serving as a social organization and by promoting medical education. These societies now have moved into the social/economic/legal area to promote your interests. What they will do for you in the future is your decision. You will determine their strength and direction.

The common denominator through all of this progress and change is the positive representation your medical societies have provided you by working for your wants and needs. They have represented a force set in motion by many people to accomplish what they could not do alone. This force gives them a single unified voice as well as individual representation. Therefore, whatever progress brings to our organization, let us make certain that any change makes it even stronger than before, ever-ready to champion our causes.

The common denominator is positive representation.

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letters to the editor

Private vs State Ethics Committees

Ed. Note: Dr. Abrams is the director of the Center for Biomedical Ethics and was interviewed in the April issue of Colorado Medicine ("Human Rights and Moral Obligations," p. 105).

Dear Editor:

Dr. Michael Victoroff's* perception of the need for dialogue, public expression and wide evaluation of these issues is precisely on target. So much, in fact, that we founded The Center for Applied Biomedical Ethics to attempt to accomplish exactly these goals; information gathering; legal interaction (our conferences are frequently co-sponsored by the American Society for Law and Medicine); a library is well underway at Rose Medical Center; we have already sponsored three conferences on institutional ethics committees and one on infant care review committees in conjunction with ASLM and the American Academy of Pediatrics is scheduled in Vail August 8-11.

Our seminars have been open to and attended by interested lay persons, lawyers, nurses, American Civil Liberty Union representatives, physicians, technicians, secretaries, medical assistants, clergy, etc. We are yet in our early stages of development but with community support for what is so clearly a community need, we can avoid the political pitfalls of an official state agency — and the risk of an official "right or wrong" position on ethical questions.

I would ask interested readers to become supporting members, to join our programs, to suggest new ones, to contribute articles to our newsletter and use its calendar and opinion columns to network with other interested persons throughout Colorado and the West.

We are planning programs with Colorado Hospital Association, American Hospital Association and more with the President's Commission's former members. Plans to meet with the judiciary are also being implemented, to further exchange of viewpoints — medical and legal. Hopefully, we can combine our efforts and, coming from the private, voluntary sector, make an impact on biomedical ethics for the betterment of our state and beyond.

Sincerely,
Fred Abrams, MD

*"For The Common Good: A Colorado Council on Bioethics," by Michael Victoroff, MD, Colorado Medicine, April, 1984, P. 107.

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DRGs—Friend or Foe?

Robert A. O'Dell, MD, Member, Board of Directors, Colorado Medical Society

"Thank you, Doctor for returning my call. This is Dr. Bob O'Dell. I'm a physician advisor (PA) to the PRO which reviews hospitalized patients for payment under DRG regulations. Your patient, Mrs. Doe, was referred to me by one of the reviewers and I need some additional information."

Have you received such a phone call yet? If not, you probably will! Colorado Foundation for Medical Care is the federally-designated Professional Review Organization (PRO) and has begun to review all Medicare and certain other hospitalizations according to Diagnostic Related Group (DRG) guidelines. These guidelines (or "criteria") include 1) validation of principle diagnosis (reason for admission to hospital); 2) intensity of services (were acute hospital services necessary and provided to the patient); 3) readmissions within a week of discharge; 4) transfers to another hospital, and a few other special situations. If the nurse review coordinator cannot verify these items from the hospital record, he/she then calls a physician advisor (PA) who may identify enough from the record to fulfill the criteria or he may call the attending physician for further information. If the PA still cannot satisfy the criteria, he will recommend a change in principal diagnosis or deny payment for the hospital stay. If the attending physician or the hospital disagrees with the decision of the PA, the case can be appealed to a panel of physicians which makes the final decision.

Common referrals are:

1. Patient with chronic heart disease who develops abdominal pain. Principal diagnosis is "abnormal pain," not "arteriosclerosis."

Result: You won't be called on this.

2. Patient arrives in the ER with vague symptoms such as abdominal or chest pains, SOB, weakness, etc., and is admitted for general hospital care (no monitor, no ICU, no IV, no stat scans, no surgery consult, etc.). Nursing reports normal vital signs and normal behavior: patient slept well, up to bathroom, pain relieved with oral medication, no vomiting, diarrhea or dizziness, patient is hungry, wants to go home). Lab tests are normal. Attending physician records "symptoms subsided, lab and x-ray WNL, home soon.

Final diagnosis is gastroenteritis (or chest pain, cause undetermined, or lower back pain, or constipation, or weakness.)

Result: you will probably be called on this case, and hospital payment may be denied.

3. Patient with COPD and principal diagnosis of "acute respiratory

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of the

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Ostomy Association

With the approval of the attending physician, carefully trained volunteers who have successfully adjusted to ostomy surgery, visit the patient. Personal experience and compassion enable the volunteer to communicate emotional support. No medical advice is given.

For more information

American Cancer Society
Colorado Division, Inc.
321-2464

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failure." Goes home on oral medication and VNS after 10 days in hospital. Two days later (often on Saturday) he returns to ER complaining of SOB and DOE and is readmitted. Oral and respiratory therapy resumed and he is discharged two days later (Noon on Tuesday). Nursing notes are similar to #2 above.

Result: You will be called!

So, what is to be done? Can we learn to tolerate DRGs? Or will DRGs cause serious splintering of the health care system? Doctors (physician advisors are doctors, too) versus doctors, doctor versus hospital, hospital versus third-party-payer, patient versus all of the above? Hopefully, we can avoid such a disaster. Here are my suggestions:

1. Avoid hospital admission for "convenience," i.e., weekend or night ER visits which could be stabilized, sent home and re-evaluated in the office the next day; out of town patients who could live in a motel while being worked up (or getting PT; patients who "live alone;" patients with "no transportation;" workups or procedures which can be done as out-patients, i.e., scopes, x-rays, PT, oral pain or diabetic control, etc.

2. Order acute hospital services if appropriate: CCU for chest pain evaluation; IVs for possible bleeders; IV medication for vomiting or abdominal pain; consultation sooner rather than later; stat scans for possible PE or CVA.

3. Start discharge planning upon admission! A discharge plan which has to be changed or postponed is excellent evidence of the need for acute hospital services.

Will DRGs splinter the system?

4. Write to us! The PRO and the PA never see the patient. Our only information comes from the hospital record, unless the PA has to call you. Record early why the patient needed to be admitted. Comment in your progress notes on required intensive services. Write so we can read it after it has been xeroxed. Record any discrepancy between your evaluation of the patient and that of others, including nurses, therapists, family members and . . . yes, the patient himself ("I need to stay here until Saturday").

At this time, PRO and PA review tend to be quite strict. There will, no doubt, be many phone calls, frequent denials, numerous appeals and significant reversals by appeal panels. That's how we learn about the system. So please be cooperative and patient with us.

"Well, Doctor, I've decided to deny DRG payment for this admission. Of course, if you disagree, you may appeal my decision."

I hope you don't have to hear these words often!

Fractionated Lexicon—For Today's Organized Physician

by Clyde Stanfield, MD

Unity: A virtue devoutly sought from its constituents by leadership.

(Continued on next page.)

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PRESTIGE IN PRACTICE

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(Continued from previous page.)

Leadership: A condition brought on by election or appointment to office or board, sometimes arrogated by self-appointed "wheels". Common after-effect: "Why am I spending this kind of time when my colleagues are out there earning a living?"

Constituents: Dues-paying members, who'd often rather not "get involved in medical politics." They're prone to be poorly informed until after the facts.

Staff: Salaried types, from the EVP on down. They have advantages of more time, experience and continuity (beyond a given administration); assets of technical and administrative expertise. Substantial disadvantages: having to do what leadership directs, getting sacked when it doesn't work.

Solidarity: Grass-roots unity among constituents, not uncommonly viewed by leadership as insurrection by the masses.

Medical administrators: A category of the unemployed after World War II (then so titled). They've found a future in the health care industry and its bureaucracies — that demand spawned by the Regulated Society, economic realities and the inherent administrative ineptness of physicians.

Fee Freeze: Voluntary constraint exhorted upon private practitioners, not on salary. Escalating dues and overhead don't count and both below-cost Medicaid and discounted PPO services mustn't be averaged in.

Third party payers: A broker type, doing business at the level between patient and doctor/hospital. They collect in advance from the former, prudently invest the funds while processing, auditing, reducing and delaying payment of claims to the latter. Resources include computers, volume deals, PSRs, HMOs and small-print exclusions.

Fee-for-service: A quaint system left over from the era of capitalistic medicine. It fostered shared incentives for both patient and doctor, in such spheres as financial accountability, utilization, personalized relationships — and even house calls.

Solidarity: unity or insurrection?

Convenience clinics: Shopping center-type facilities for fast pre-primary medical services; designed for consumer accessibility and appeal. They're spared the burden of charitable services and the uncertainties of bad debts, so easily are less costly, more efficient and not subject to JCAH complexities. But they're not your vintage "Doc".

DRG: Obsolete acronym for "Denver & Rio Grande Railway," and for "Denver Runs God" (recently disproved). Most commonly, a euphemism ("Diagnosis Related-Groups") for rationing down prospective payments for hospital care, apart from cost, quality or accessibility. Compare with another budgetary euphemism for medical care rationing: "selective allocation of health resources."

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BY MICHAEL GARMAN

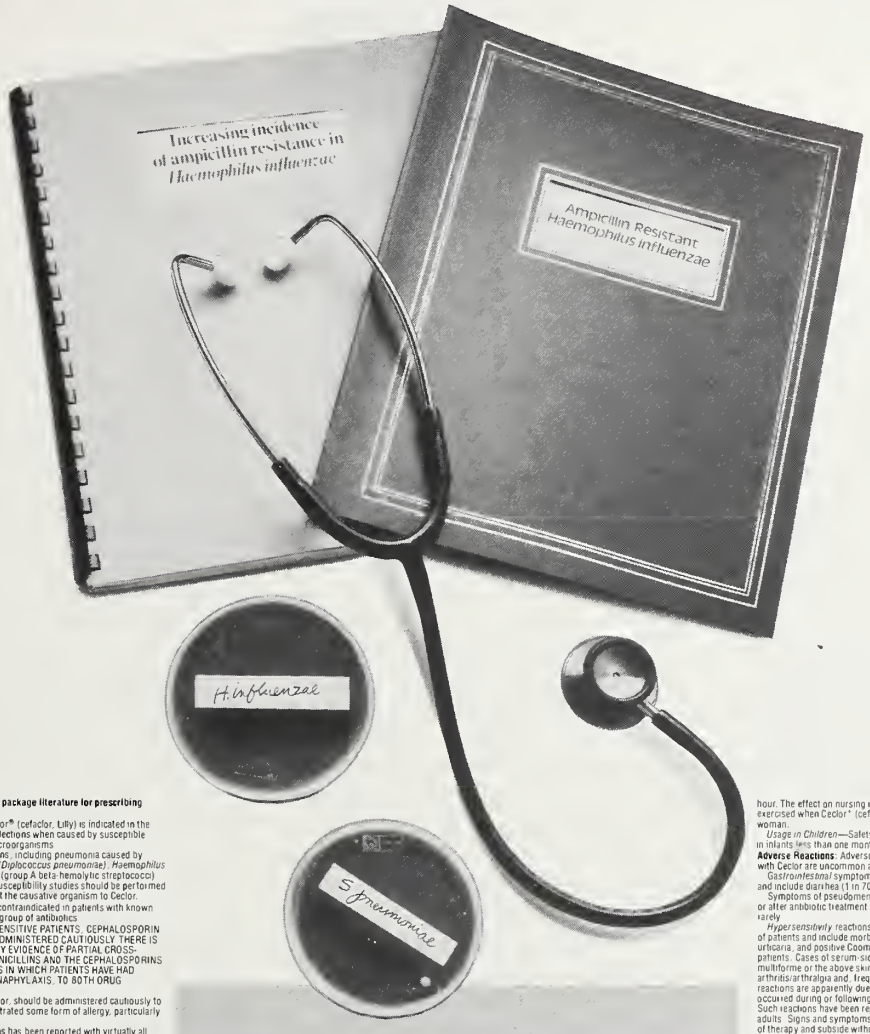


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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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auxiliary report



Bunkie Inkret, President
Colorado Medical Society Auxiliary

Prescription for a Healthy Family

On Wednesday, April 25, the Colorado Medical Society Auxiliary held a general membership meeting in Denver. At this meeting, Richard Lindsay, Ph.D., addressed the group and presented his ideas entitled "Prescription for a Healthy Family." Dr. Lindsay is the Managing Director of Public Affairs, The Church of Jesus Christ of Latter-day Saints.

Let me share some of these thoughts with you. I ask that you read them; perhaps if we all try to add a few of these ingredients to our personal lives and share them with our families and friends, we can alleviate many of the pressures and strains in our families.

The growing national concern for the present condition of the family is a hopeful and refreshing sign if it results in deliberate efforts to better the social/emotional health and improved functioning of families and improves their role as society's greatest resource in solving the problems of our time.

A wise social order begins with the axiom: What strengthens the family strengthens society. The family is the seedbed of economic skills, money habits, attitudes toward work and the arts of financial independence. The family is a stronger agency of educational success than the school. The family is a stronger teacher of religious belief than the church. If things go well with the family, life is worth living; when the family falters, life falls apart.

The family is the primary teacher of moral development. Economic and educational disciplines are learned best in the home; if not there, hardly at all. The family nourishes "basic trust." From this trust springs creativity, psychic energy and a sense of social justice.

There is not one family pattern in America; there are many. All are alike in this, however; they provide such civilization as exists in the United States with nurturing grace and hope, and they often suffer greatly under the attacks of the media, the economic system and from well-intentioned public programs.

Aggressive sentiments against marriage are often expressed today in the name of freedom, openness or serious commitment to a career. Marriage is pictured as a form of imprisonment, oppression, boredom and chafing hindrance. These accusations are not entirely wrong. While marriage does indeed impose humbling and often frustrating responsibilities, these challenges are precisely the preconditions for true liberation. Marriage is not the enemy of moral development in adults. Rather it is the opposite.

A frightening statistic is pointed out in the September, 1983 edition of *American Demographics*. Fully 59 percent of children born in 1983 will live with only one parent before they reach the age of 18, according to estimates by Arthur J. Norton, Assistant Chief of the Population Division of the Census Bureau.

Children live in single-parent homes because they are born to unwed mothers, because their parents split up, or because a parent dies. Recently, one of the country's most respected sociologists, Dr. Amitai Etzioni warned "that if we continue to dismember the American family at the present rate, we shall run out of families before we run out of oil." Although Dr. Etzioni surely does not seriously believe there will be no married couples in America in future, to any thoughtful observer the tearing at the fabric of family life and the relationships of family members are self-evident.

Experts differ somewhat concerning the psychological effects of divorce on children although most concur that the psychological impacts are generally adverse to children. A negative effect on their economic well-being is almost inevitable. Before divorce, two parents and their children share one household, benefiting from economics of scale and from cooperative endeavors of the partnership. After divorce there are typically two households to maintain. The economies of scale are lost and cooperative effort is more difficult if not impossible.

Moreover, in most cases fathers provide little or no child support when the mother has custody. Fewer than half of such mothers receive support payments from the father. Many divorced mothers must work full time to support their children and others depend partly or totally on government subsidy. Even so, more than 50 percent of the children in families headed by a woman live in poverty, compared with only eight percent in husband-wife families, according to Victor R. Fuchs, Professor of Economics, Stanford University as quoted in the *New York Times,* September 7, 1983.

Those wondering how children fare in one-parent households can draw on a growing body of professional advice and evidence, much of it discouraging. Again from Dr. Etzioni, "In all my professional and personal experience, I have not seen a single child who did not suffer to some degree, physically or psychosomatically, from divorce."

The assault on the family, particularly since the 1960s, together with growing economic stress, have given rise to any number of changes in families that earlier would have been considered deviant but now simply are referred to as "variant". Accompanying these drastic changes, however, have been recent warnings from many experts that there "is no substitute for the

family," and these same experts are predicting that if current social trends mitigating against families are not checked, the long-term social consequences will be disastrous.

In the face of the rampant and well-publicized social indicators pointing up the pathology of the American family, what are some of the practical, time-tested recommendations for making our families what God intended and what we so want them to be? In her new book, *Traits of a Healthy Family,* parent educator Dolores Curran of Denver polled 500 social workers, counselors and other experts to determine what factors make for successful families. Among the traits most often mentioned are:

- A willingness to speak and listen thoughtfully to each other.
- The ability to bring quarrels to a quick and satisfying conclusion, without bearing grudges.
- Clear parental guidelines on right and wrong.
- The sharing of a common religious or ethical core.
- Respect for each other's privacy.
- A desire to share some, but not all, leisure time.
- A system for sharing responsibility.
- Development of a spirit of voluntarism and community service beyond the family's immediate needs.
- Easy interaction among all family members. Everyone is encouraged to participate in activities, and creation of factions is discouraged.
- Creation of a strong sense of unity and a respect for family traditions.
- An atmosphere of playfulness and humor, but without sarcasm or put-downs.
- A willingness, when serious problems can't be solved, to go outside the family for help.

From a dear friend and colleague, Richard W. Linford, an attorney, lay churchman and father of eight, I have the following list of "Twenty Ways to Make a Marriage Great:"

1. Night and morning prayer, to say thanks, to ask for help in your marriage and family, to worship together.
2. A weekly planning meeting, to discuss the calendar, talk over needs and problems, decide priorities and next steps.
3. A daily phone call or personal conversation, to say "I love you," to touch base, to discuss the day, to show you care.
4. A weekly date to a favorite park, a concert, the library, the gym, or staying home for a candlelight dinner, a game or a mutual hobby.
5. Patience, regardless of missed meals, tardiness, forgotten favors, a thoughtless remark, impatience.
6. Daily service to each other, helping with house or yard work, mending a piece of clothing, taking a turn with the sick baby, fixing a favorite meal.
7. A budget to tie down income and expenses, help set financial goals and give you control over your finances.
8. Listening—not only to what is said, but also to what is meant.
9. Regular attendance at church or synagogue.
10. Reading from the scriptures and/or uplifting literary works, to receive inspiration for yourself and your marriage.
11. Working together... caring for a garden, painting a bedroom, washing the car, etc.
12. Forgiving each other daily; always learning from each other, trying a different way, being the first to make peace.
13. Courtesies, like saying please and thank you, not interrupting or belittling, not doing all the talking, continuing the niceties of courtship.
14. Soft and kind words, of tenderness, compassion, empathy.
15. Learning together by reading to each other, discussing ideas, taking a class.
16. Respecting opinions, ideas, privacy.
17. Supporting your spouse's efforts, projects and activities outside the home.
18. Caring for your spouse's family by enjoying their company, praying for them, serving them, overlooking differences.
19. Occasional gifts, such as a note, a needed item, but mostly gifts of time and self.
20. Loving with all your heart.

Nearly 35 years of happy married life have convinced me of the efficacy of this formula. I have learned, however, that in church life and in many other pursuits of life, after all is said and done, more is usually said than done. These simple steps, thoughtfully and consistently pursued, will provide a tremendous lift to the quality of marriage and family life.

The values people live by are to a large extent a function of the quality of their family life and the training they received when they were children. Healthy, mature, vital people embrace solid and constructive values and society moves forward.



Shown, l to r Rose Pollard, Chairman, CMSA AMAERF Committee, University of Colorado School of Medicine Dean Norman Weiner, M.D., Bunkie Inkret, President, CMSA, and John A. Whitesel, M.D, President, CMS, as the CMSA presented Dean Weiner with checks totaling more than $17,000. These funds were raised by the AMAERF Committee during the preceding year to go toward medical education and research, and are distributed to medical schools across the country to aid students in these areas.

Tennant to be New VP of Health Board

Carroll Rushold, a nursing home and hospital administrator from Palisade, was elected president of the Colorado Board of Health at its April meeting and Edward E. Tennant, MD, a radiologist from Sterling was elected vice-president.

Tom Vernon, MD, executive director of the Colorado Department of Health, is secretary to the board, which meets monthly to adopt health and environmental rules and regulations and to set general policies for the enforcement of health laws.

Mr. Rushold has served on the board for five years, representing the Third Congressional District. He is executive director of the Lower Valley Hospital, the Lower Valley Nursing Home, a 120-bed skilled care facility, and Independence Village, a 75-unit low income and handicapped housing project in Fruita. A former member of the statewide Health Coordinating Council, Mr. Rushold is on the American Cancer Society Board in Mesa County.

Dr. Tennant, a member at large, was appointed to the board in spring, 1983. He is a former mayor and councilman of Sterling. Dr. Tennant is a radiologist at Logan County Hospital and at Cheyenne Memorial Hospital in Sidney, Nebraska, as well as a certified flight surgeon in the U.S. Air Force Reserve. His many professional and community service activities include acting as vice speaker of the CMS House of Delegates.

Other members of the Colorado Board of Health are: Richard N. Bluestein of Denver, representing District 1; Anne M. Gough of Arvada, District 2; John R. Bagby, Jr., Ph.D., of Fort Collins, District 4; Sherry J. Wynn of Colorado Springs, District 5; and Carol Maclennan of Aurora, District 6. Gatewood C. Milligan, MD, of Englewood and Al Hayden, Jr. of Pueblo have at-large seats.

The governor appoints the nine board members and the state senate confirms the appointments.

Labor Department Seeks Physicians for Workers' Comp Consultations

The U.S. Department of Labor plans to contract with physicians from various specialties to provide medical opinions on federal Workers' Compensation cases by consultations and/or case file reviews.

Carol Fleschute, Assistant Regional Administration of the department's Employment Standards Administration, outlined the plan in a letter to John A. Whitesel, MD, President of CMS. Ms. Fleschute noted in her letter that, although federal employees covered under the Federal Employees Compensation Act with work-caused injuries or illnesses are usually treated by their own physicians, her office must obtain medical examinations and evaluations on these employees "from time to time."

Ms. Fleschute stated, "It is (the department's) wish that all physicians be offered an opportunity to participate in these consultations.

According to the department's plan, consultations will take place in the physician's office and will consist of reviewing the medical reports, conducting a medical history and examination, and preparing a report indicating the federal employee's medical condition, recommendations for medical care and opinions about the relationship of the medical condition to the employee's work. For medical case file review, physicians will be sent medical records to review and prepare reports about medical conditions and their relation to work.

Ms. Fleschute said in her letter that fees will be paid on the basis of negotiated fee schedules, with billing for each case. Interested physicians should call 837-5402 or write to the Employment Standards Administration, Department of Labor, 1961 Stout Street, Denver, 80294.

Beth Israel Education Center to Hold Geriatrics Conference

Beth Israel Education Center will hold its second annual geriatrics summer conference July 18-20 at the Sheraton Inn in Lakewood. The theme of the conference will be "Confusion: It's Not All In Your Head" (Altered Mental States In the Elderly).

A number of distinguished geriatricians from various health care disciplines will speak at the conference. For information contact LeRoy King, Ph.D., Education Director, Beth Israel Education Center, 1601 Lowell Boulevard, Denver, 80204. (303) 825-2190, ext. 266, 457 or 358.

Unique Conference to Bring Physicians and Musicians Together

Does music training change the way the brain works? What can a pianist learn from a quarterback? How well do symphony conductors keep time?

These are among the questions that will be discussed by music educators, musicians and physicians at "The Biology of Music Making" conference, which will take place July 8-12 in Denver.

The event is sponsored by the University of Colorado College of Music and Health Sciences Center and The Denver Center for Performing Arts, where the conference will take place.

The conference was created by Dr. Frank R. Wilson, clinical professor of neurology, University of California School of Medicine in San Francisco, chief of the Department of Neurology, Kaiser-Permanente Medical Center, Walnut Creek, California and consultant to the American Music Conference.

The conference will probe physiological, psychological and biological foundations of musical skills in a forum which will include lectures, demonstrations, workshops and panel discussions.

For further information contact Martin J. Wilson, The Denver Center for Performing Arts, 1245 Champa, Denver, 80204. (303) 893-4000.

Local Physicians Film National Laser Graduate Course

Arlen D. Meyers MD, Director of the Institute for Laser Medicine at Saint Joseph Hospital and Elsa M. Swyers, MD, attending physician at Saint Joseph Hospital recently appeared as co-presenters in a postgraduate telecourse entitled "Lasers in Medicine: Healing Energy."

The telecourse is a production of the Network for Continuing Medical Education in New York City. These courses are seen in more than 700 hospitals and medical centers throughout the U.S. and Canada.

Saint Joseph's Institute for Laser Medicine was formed in 1980 under Dr. Meyer's direction to further the development of medical applications of lasers in surgery and in treatment of disease and to educate physicians nationwide in the use of lasers. The institute sponsors conferences and workshops for physicians and operating room staff. It is the only program of its kind in the Rocky Mountain West.

Denver Physician Elected to ACP Fellowship

The American College of Physicians recently elected Jan Paul Goldberg, MD, of Denver to fellowship in the national medical specialty society. Dr. Goldberg, a nephrologist, is one of 250 physicians who have been elected to the ACP this year. Dr. Goldberg, a 1976 graduate of the University of Colorado Health Sciences Center, is on the staff of the Rose Medical Center, Mercy Medical Center, Humana Aurora Hospital and Presbyterian-St. Luke's Medical Center.



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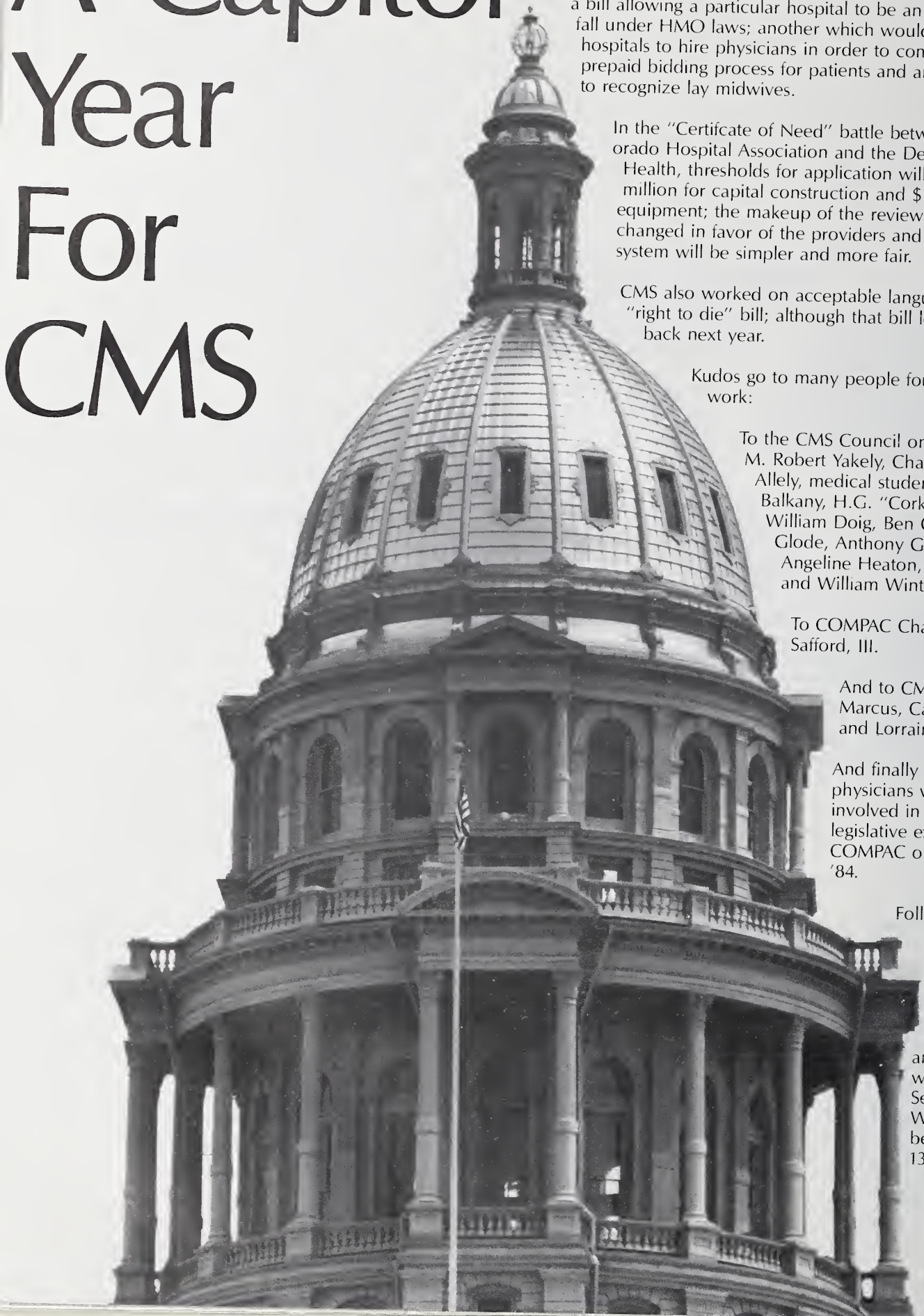
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A Capitol Year For CMS



CMS recently completed its most successful legislative yet! CMS won a victory in its tort reform efforts by ins an exemplary damage phrase in a bill addressing the obligation for attorney fees. CMS worked actively to d a bill allowing a particular hospital to be an HMO but fall under HMO laws; another which would have allo hospitals to hire physicians in order to compete in a prepaid bidding process for patients and another atte to recognize lay midwives.

In the "Certifcate of Need" battle between the C orado Hospital Association and the Department Health, thresholds for application will be raised million for capital construction and $1 million fo equipment; the makeup of the reviewing body w changed in favor of the providers and the applic system will be simpler and more fair.

CMS also worked on acceptable language for th "right to die" bill; although that bill lost, it will back next year.

Kudos go to many people for all their h work:

To the CMS Council on Legislatio M. Robert Yakely, Chairman; Eric Allely, medical student; Tom Balkany, H.G. "Corky" Butler, William Doig, Ben Galloway, Glode, Anthony Gottlieb, Angeline Heaton, Robert Sa and William Winter.

To COMPAC Chairman H.R Safford, III.

And to CMS staff, Ch Marcus, Carol Tempe and Lorraine Koehn.

And finally to all the physicians who becam involved in the CMS legislative effort, throu COMPAC or Participat '84.

Following this page is an ticle, "Di of a Bill,' on the C tort refor effort. Al an interview with retiring Senator Har W. Phelps begins on p. 136.

Diary of a Bill

(or, How CMS Became Involved in Tort Reform)

"We survived two House/Senate conference committee meetings on SB 182. This bill was our final hope to incorporate some of our exemplary damage language from the bill we introduced as HB 1162. We won a phrase that hopefully will put a damper on frivolously filed malpractice suits; but more importantly we won many allies and an ability to return to the arena and ask for more."

As I wrote that language in the Legislative Report dated April 28, 1984, I found myself thinking of all the efforts and hours that had gone into the tort reform effort in the last months and decided it might be interesting to attempt to recap those efforts. Multiply the hours by three because the Council on Legislation/Dr. Robert Yakely, Charles Marcus and I did this together. The Council/Dr. Yakely served as the physician advisor, Chuck was the expert on insurance and I served as the lobbyist with the contacts with the legislators.

— Carol Tempest, CMS Lobbyist

Late February, 1983 CMS was approached by other lobbyists and told that legislators were interested in a tort reform package that would hopefully help malpractice insurance rates and thus address the health care cost containment issue. We met with the speaker of the House, Representative Bledsoe (R), Hugo, and the majority leader of the House, Representative Ron Strahle (R), Ft. Collins, and found that they were indeed interested and wanted a bill written that would place a ceiling on damage suits for pain and suffering.

March, 1983 We worked on an ongoing basis with Jim Perrill, an insurance lobbyist, attorney, and former state senator. We drafted several versions of the bill and were assured that a bill would be given "late bill status" and introduced with the idea that a new concept usually takes at least three years to pass. However time ran out with the bill never being introduced, and the only attempt at tort reform came when Representative Robb (R), Grand Junction, and Representative Strahle moved on the floor of the House to attach to a wrongful death bill the awarding of punitive damages to a fund rather than to the plaintiff. This failed.

Summer and fall, 1983 In late June when the legislature was not in session we began working once more on tort reform. It was obvious in working with Representative Bledsoe and Strahle that they wanted slightly different approaches. Representative Bledsoe wanted the ceiling on pain and suffering damages and wanted it to apply as broadly as possible. Representative Strahle wanted punitive damages to be the punishment they were originally intended to be and be placed in the victim's compensation fund in the judicial district in which they were awarded. Representative Robb took on the latter bill, had it written on the legislative drafting office, and became its prime sponsor. Again with Jim Perrill, we wrote several more versions of the pain and suffering bill and finally had one that all could accept. With Representative Bledsoe's help, Representative Artist (R), Greeley, became the sponsor. Throughout the summer and fall, Chuck Marcus represented CMS on the governor's task force on health care cost containment and also on the Health Care Forum and made sure that tort reform was listed as a necessary part of any package.

December, 1983 Representative Strahle "invented" a third bill, one that placed a ceiling on the amount for which a physician member of a professional corporation could be sued. We met several times with Representatives Bledsoe and Strahle to plot strategy — time of introduction, committee to which assigned, etc. Then we met with Senator Strickland (R), Westminster, the president of the Senate. We talked about senate sponsors for the three bills and again about committee assignment.

January 10, 1984 House Bill 1162 was introduced and assigned to the House Judiciary Committee. Its title read: "Concerning the Assessment of Exemplary Damages Under Section 13-21-102, Colorado Revised Statutes." The bill's summary read as follows: Requires that exemplary damages awarded in any civil action be placed in the crime victims compensation fund in the judicial district in which the action was commenced and that attorney fees may not be deducted from such damages. Makes a conforming amendment to the statute which establishes the crime victims compensation fund.

February 2 HBs 1355 and 1400 were introduced and assigned to the House Business Affairs and Labor committee. Their titles read:

HB 1355, Concerning Medical Professional Service Corporations, and Relating to the Liability of Such Corporations and the Employees Thereof.

Bill Summary: Specifies that the amount of a medical professional corporation's liability insurance on each claim provided by a policy which meets the statutory requirements for coverage shall be the maximum amount of liability on each claim of the corporation and the professional or non-professional employees and shareholders of the corporation for acts, errors, and omissions covered by such policy.

HB 1400, Concerning Limitation on Damages in Personal Injury Suits.

Bill Summary: Limits the dollar amount of recovery awardable to a personal injury plaintiff as compensation for physical pain and suffering.

February 3 Because we were unable to count enough sure votes to pass HB 1162 in the Judiciary Committee, the bill's sponsor (Representative Robb is also chairman of the Judici-

ary Committee) was able to move the bill to the Business Affairs and Labor Committee. (Throughout this period of time, we were working closely with lobbyists from the insurance industry and building alliances with business lobbyists and staff at the Colorado Association of Commerce and Industry.)

February 4-15 We prepared necessary background material for the sponsors of the three bills and met with Representative Minahan (R), Colorado Springs, the chairman of the Business Affairs and Labor Committee. The background material for Representative Robb's bill even included a history of punitive damages prepared for us by a retired judge. We discussed the bills with each member of the committee and prepared George Thomasson and Roger Johnson for oral testimony. . . . Senate sponsors were acquired; Senator Arnold (R), Littleton, for HB 1352, and HB 1400; Senator Hefley (R), Colorado Springs for HB 1162.

February 9 HB 1355 was scheduled for a 1:30 pm committee hearing. I had to leave for a Mesa County Medical Society meeting at 4 pm and the bill had not yet been heard. A phone call from Chuck at 6:30 told me the ceilings had been amended upward but the bill had passed unanimously and had been sent to the Rules Committee for calendaring for floor action.

February 15 Both HB 1162 and HB 1400 were heard in committee, passed by 8 to 2 and 9 to 1 votes, and sent to the Rules Committee. HB 1400 was amended to apply only to medical malpractice.

February 21 The chairman of the Rules Committee, Representative Mielke (R), Lakewood, finally allowed HBs 1162 and 1400 to be calendared but refused to calendar HB 1355, thus killing it. He is a plaintiff attorney, and it was only the pressure of the House leadership that saved the other two bills.

February 23 HBs 1162 and 1400 were scheduled for floor debate in the House. Chuck was in Arkansas with the National Guard, so I spent much of the day attempting to find out how each of the 65 House members was going to vote. At noon I turned the vote counts over to the bill sponsors with the knowledge that both counts were extremely close. It had been announced that the House would meet until it finished its calendar with one and one-half hours off for a dinner reception. Our bills weren't heard in the afternoon and faced a tired and grumpy group of legislators who had returned from a crowded, understaffed reception. Three hours of technical legal debate took place, primarily on HB 1162 which was scheduled first. Attempts to kill it failed, but it was amended as follows:

> (2) Upon a finding by the court that a claim for exemplary damages, in any pleading filed by any party, is frivolous, vexatious, or groundless, the court shall enter an order requiring the payment by the party who made such claim and his attorney, jointed and severally, to the party against whom such claim was made, of all costs, including attorney fees, incurred by the party in defending against such claim in deciding whether or not a claim is frivolous, vexatious, or groundless, the court shall take into account the circumstances described in subsection (1) of this section.
>
> (3) From any exemplary damages actually recovered pursuant to subsection (1) of this section, reasonable attorney fees shall be deducted, calculated on an hourly basis, and the balance shall be distributed equally between the claimant and the crime victim compensation fund in the judicial district in which the award is granted.

The recorded vote was 31 to 26 in favor of the bill, but I went home knowing that a bill must have 33 votes on final reading the next day. The House was not about to give us two victories and the plaintiff lawyers none, and HB 1400 was defeated at about 11 PM.

February 24 I arrived at the capitol early to be sure I had two extra votes and that my "aye" votes from the night before had not changed their minds. HB 1162 was passed by a 37 to 28 vote.

February 28 HB 1162 was introduced in the Senate and was sent not to Business Affairs and Labor as had been promised but to the Judiciary Commitee. The committee chairman, Senator Cole (R), Littleton, is an opponent of tort reform bills and after scheduling the bill three times, refused to let it be heard. Thus it died.

March 31 Representative Strahle found a Senate bill, SB 182, with the title, "Concerning the Obligation of Colorado Courts to Assess Attorney Fees Under Certain Circumstances," and added the following paragraph:

> Upon finding by the court that a claim for exemplary damages, in any pleading filed by any party, is frivolous, vexatious, or groundless, the court shall enter an order requiring the payment, by the party who made such claim and his attorney, jointly and severally, to the party against whom such claim was made of attorney fees incurred by the party in defending against such claim. In deciding whether or not a claim is frivolous, vexatious, or groundless, the court shall take into account the circumstances described in this section.

Some of the House amendments were not acceptable to the Senate sponsor, Senator Arnold; so the bill went to a conference committee.

March 29 I left town for a day with promises from four of six of the conferees to leave our amendment in the bill. After testimony by attorneys, the agreement appeared to be in trouble; and Senator Spelts recessed the meeting so that Chuck and the opposition could work out their differences.

April 3 The conference committee reconvened, struck our amendment, and amended the legislative declaration to read:

> The general assembly recognizes that courts of record of this state have become increasingly burdened with litigation which is straining the judicial system and interfering with the effective administration of civil justice. In response to this problem, the general assembly hereby sets forth provisions for the recovery of attorney fees in courts of record when the bringing or defense of an action, or part thereof (including any claim for exemplary damages), is determined to have been substantially frivolous, groundless, or substantially vexatious.

So 14 months later the tort reform effort lies dormant for just long enough for us to catch our breath and start again for the next legislative session. A multi-disciplinary committee is being formed under the auspices of the CMS Council on Legislation and Dr. Gerald Rainer, CMS President-elect. Candidates will be told the glories of the decisions we reach, and we'll be off and running.

Public Servant & People's Advocate:

A Conversation with Senator Harvey Phelps

Ed. Note: After eight years as Colorado Senator from Pueblo, Harvey W. Phelps, MD, is stepping down. He says that "four years is too short" a time in office, but "eight years is too long." He has had a long and active career in public service. Colorado Medicine Publications Editor Sheila Swan talked with Dr. Phelps recently about some of his many experiences and accomplishments.

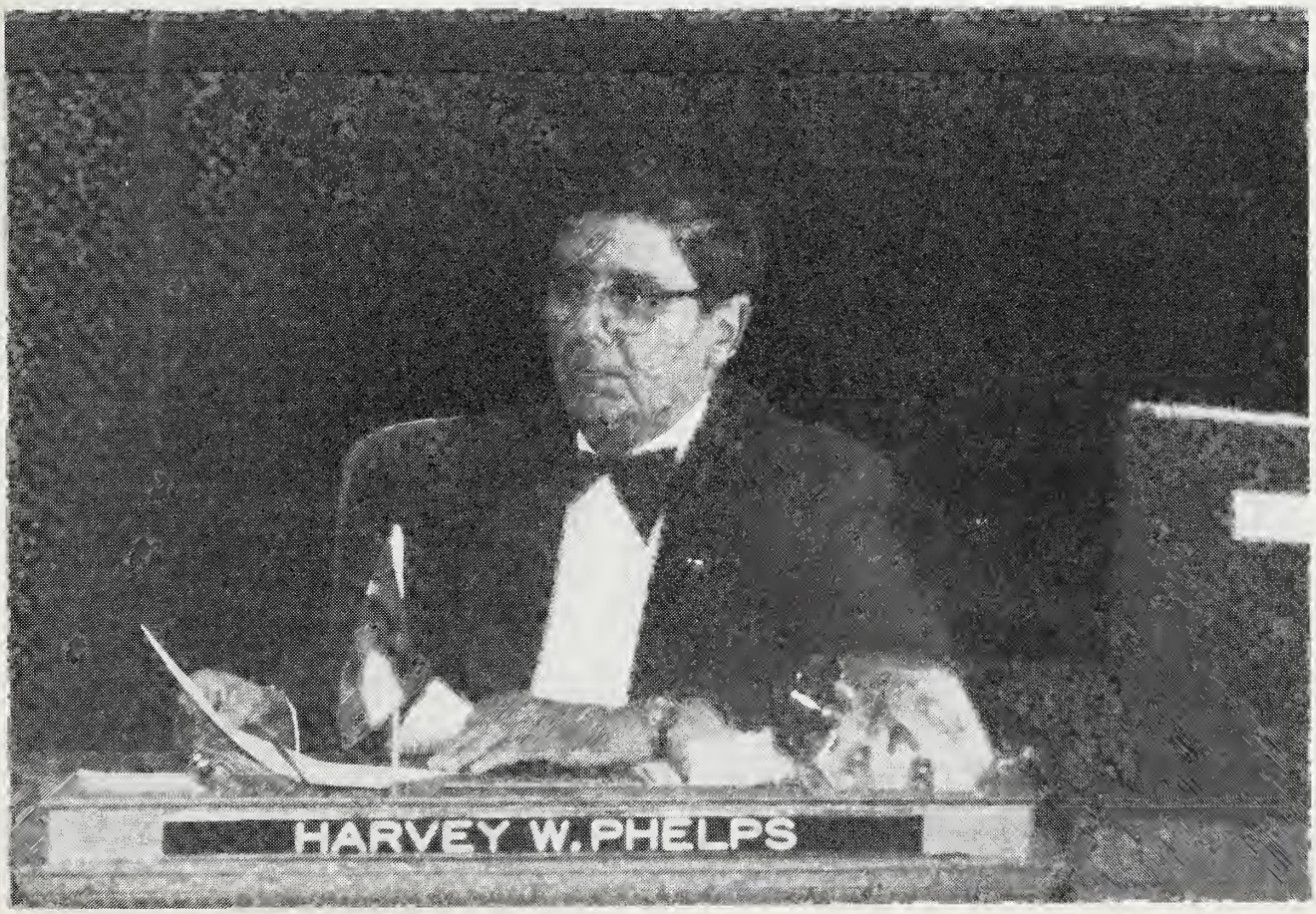
Involvement in politics has brought Senator Harvey W. Phelps, MD, of Pueblo many unforeseen experiences — such as arresting the county sheriff, which he had to do on four separate occasions when he was Pueblo County Coroner.

"Malfeasance in office" was the charge on all four occasions, and it came as a surprise to Dr. Phelps to learn that he, as highest-ranking officer in the county, was the only person authorized by state law to arrest the sheriff — a duty he hadn't contemplated when he ran for the position. He also didn't realize that, after arresting the sheriff, he would have to take charge of the county jail and become acting sheriff himself. Fortunately, his experience as sheriff only lasted as long as it took the arrested officer to post bond; several hours in three of the cases, one day in the other.

Arresting sheriffs is only one of many experiences Dr. Phelps has had during his political career.

Dr. Phelps, a Pueblo native, returned to his hometown in 1966 after retiring from the Army as a lieutenant colonel with 20 years of medical service. A chest physician, he became Director of Inhalation Therapy and Pulmonary Function Laboratories at St. Mary Corwin Hospital and Parkview Episcopal Hospital from 1966 to 1972. From 1972 to 1976 he was chief of staff at Parkview Episcopal Hospital. However, after being elected to the state legislature in 1976, time and distance constraints forced him to give up his practice and many of his medical activities.

Several child abuse cases in Pueblo prompted Dr. Phelps to begin his political career by running for coroner; that, he says, and being the "only physician in Pueblo County who was a Democrat." At that time,









he comments, "you couldn't get elected dogcatcher unless you were a Democrat."

A number of factors influenced Dr. Phelps to run for the state legislature. In 1974, a group of coal miners approached Dr. Phelps to run for national office. The Pueblo Medical Society urged him to run for office as did his daughter Nancy, who was killed in a car accident in 1972. Although he lost the US Senatorial nomination to Gary Hart, he ran for the Colorado Senate and was elected in 1976.

Dr. Phelps' many political interests include health care legislation, jobs and housing for low-income working people, reclamation projects and air pollution control. One of his particular concerns has been the economic problems of the coal miners of southern Colorado and New Mexico. "The United States became a rich, independent country on the backs of the coal miners," he notes. As a medical witness, Dr. Phelps secured the first benefits under the Black Lung Act for four coal miners in New Mexico. He believes the Black Lung Act was "poorly written and loosely constructed;" as a result of which New Mexico and Colorado coal miners were largely eliminated from benefits. The law, Dr. Phelps notes, should provide a pension for the miners rather than make them prove disability from pneumoconiosis.

Air pollution control has long been a prime interest of Dr. Phelps. He has, during the course of his career, presented and published a number of clinical research papers on the effects of air pollution and directed one of the first studies on the effects of air pollution on humans. He proudly notes that the city of Pueblo and Colorado Fuel and Iron have succeeded in cleaning up Pueblo's air, changing it from Colorado's most polluted city to one of the least polluted in Colorado. Not so Denver, which Dr. Phelps believes has become concerned with air pollution many years too late. He says, too, that Denver is located in "the worst possible place to build a city," in a river valley next to a mountain range. The mass business and recreational construction in downtown Denver has made matters much worse. Twenty years ago, he suggests, a sit-

ing authority should have been established to tell developers where to build. Diffuse growth, too, means problems in developing efficient mass transit.

At this point, although he says Denver's pollution problem will never be solved, the city should concentrate on controlling diesel pollution and banning wood-burning stoves and fireplaces. He comments that London banned the use of fireplaces more than 20 years ago, thus ending the "killer fogs" for which the city was famous.

During his eight-year tenure in the state senate, Dr. Phelps has gotten more legislation passed than any other Democrat. The SEARCH program at the University of Colorado Health Sciences Center, he feels, is one of his most important accomplishments. Through the efforts of Dr. Phelps, Dr. David Bates of Greeley and Dr. F. William Barrows of Pueblo (now deceased) the program was established at UCHSC and received matching funds from the legislature. The SEARCH program, through Area Health Education Centers (AHECs) in Greeley, Pueblo, Fort Collins, Grand Junction and Alamosa, provides continuing education for physicians and other health care providers in rural areas of the state. SEARCH also has a rotation program for nursing and medical students "to relieve the isolation of health care practitioners in rural Colorado."

Other achievements include the bill that established the Family Medicine Commission; helping to rewrite federal disability legislation to include changes which recognize the effects of high altitude on pulmonary function and leading the effort to clean up all stationary sources of air pollution.

Another of Dr. Phelps' projects has become a great image-builder for the Colorado physician community. This is the "Doctor for a Day" program, which Dr. Phelps, with the Colorado Academy of Family Practice, began in January, 1983. Each day the legislature is in session, a member of the academy volunteers his or her time as a physician at the State Capitol. Usually, the doctor sees only minor illnesses and injuries, but with the numbers of legislators, staff, tourists and visitors who come to the Capitol, he or she may be kept quite busy. It's also a good education for the doctor, who in his spare time can sit in on legislative sessions and watch the state government at work.

Today, Dr. Phelps feels the biggest medical/health problem the legislature faces is health care for the medically indigent. "We're talking about the working poor who cannot afford the high cost of health insurance." Government programs to aid the medically indigent, he adds, "are underfunded and unequally distributed." He comments that approximately 90 percent of the available funds for the medically indigent are spent in the Denver area.

The solution, he suggests, may be state- and/or federally-funded insurance for catastrophic illness. "While I've never been in favor of totally government-funded, what some call socialized, medicine," Dr. Phelps says, if government could fund insurance to cover catastrophic illness for the medically indigent, then "these people could afford insurance to pay for the routine and ordinary (health care costs)."

After a long and active career in public service, Dr. Phelps says he is looking forward to retirement. "For



"Doctor for a Day" James Hill, MD, with Dr. Phelps

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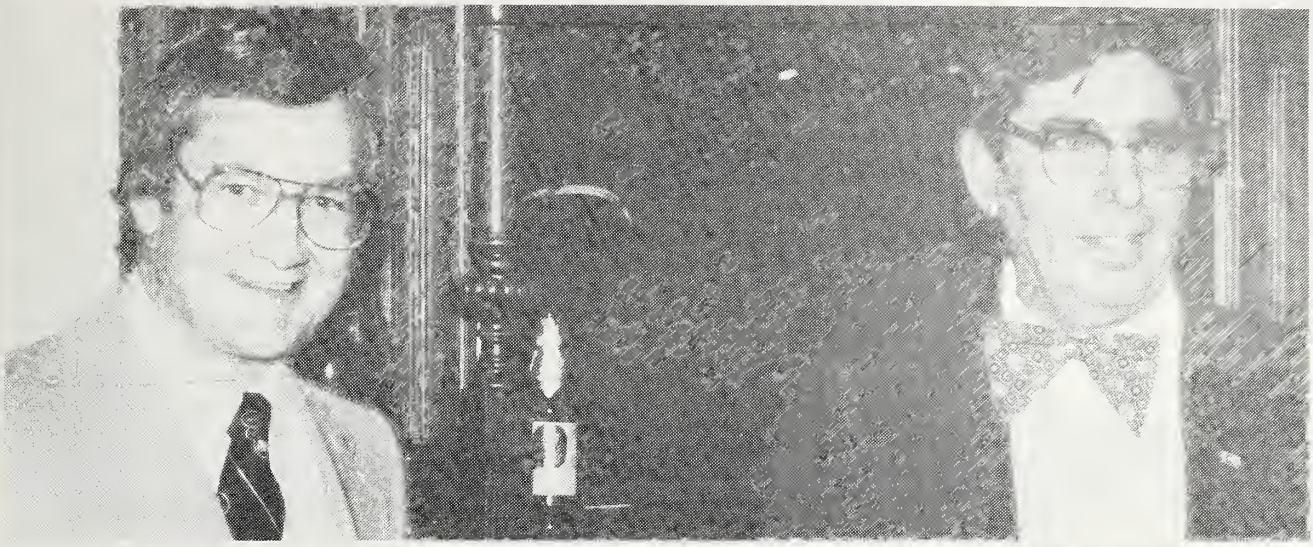


one thing," he says, "I'm getting too old for all this." Also, he and his wife, Adah, plan to spend a lot of time traveling, when they're not at home in Pueblo. Planned trips include visits to a daughter in New York and a son in South Dakota. Also, he says, "I'm just looking forward to doing a few things I want to do." However, this doesn't preclude some political activities "sometime down the road."

He does plan some part-time medical practice. And it should be noted that Dr. Phelps has long been active in his local and state medical societies. He is a member of the CMS House of Delegates and a fellow of the American College of Physicians and the American College of Chest Physicians. He is a 1972 recipient of the James J. Waring Award in Chest Diseases for his work as inhalation therapy director at the two Pueblo hospitals and for developing a two-year school of inhalation therapy at Southern Colorado State College (now University of Southern Colorado). He has received "distinguished service awards" from CMS and the Health Sciences Center.

Somehow it is difficult to believe that Dr. Phelps won't stay active in public service, whether in local or state government or through the medical societies. Carol Tempest, CMS lobbyist, tells a story about a young graduate student in communications who interviewed her for a talk show. He wanted to know if she knew Harvey Phelps, saying that he very much wanted to meet Dr. Phelps because he was so respected by his father and other coal miners across the country. "He said his father would never forgive him if he came back to Ohio without having met Harvey Phelps," Carol adds. That kind of reputation doesn't get built — or forgotten — quickly.

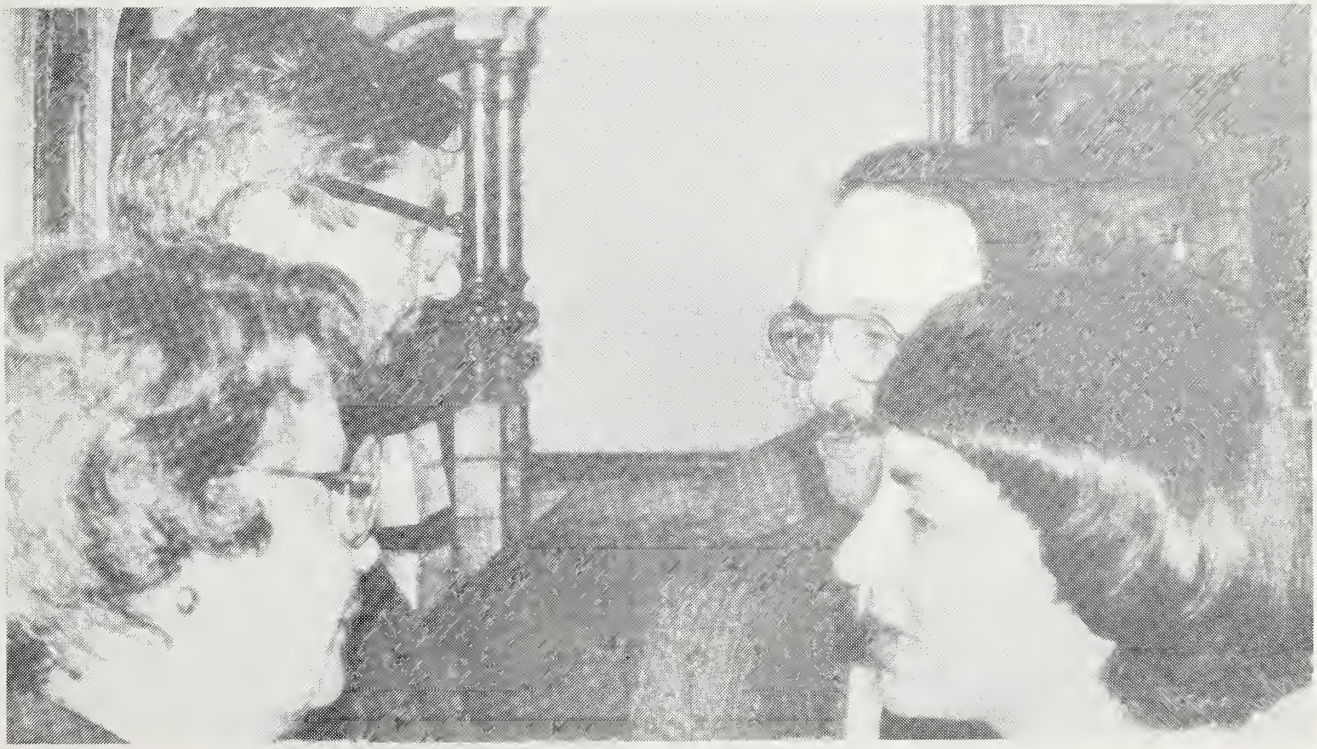
He has stated that it is important for professionals, such as physicians "to give of their time to their community or their country." One can safely say that Harvey Phelps has lived up to that motto, and no doubt he will continue to do so.



On April 9, the Colorado Academy of Family Physicians hosted a surprise party for retiring Senator Harvey W. Phelps, MD. Guests included fellow legislators, staff, friends and physicians from CAFP.

Top: Dr. Steve Thorsen, CAFP President and Dr. Phelps. Right: Senator Dennis Gallagher doing his imitation of Dr. Phelps. Bottom: Adah (Mrs. Harvey) Phelps, Dr. Phelps, Senator Jim Rizzuto and Senator Barbara Holme.





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The Basics of Estate Planning

Ed. Note: The following article was written by John H. Brown, a Denver estate-planning attorney and partner in the law firm of Minor & Brown.

In perhaps the broadest definition, estate planning is the process of planning the disposition or arrangement of your assets in order to meet your personal, family and tax objectives both during your lifetime and at your death. Estate planning is not just for the wealthy. For example, an "estate plan" may consist of nothing more than a will. On the other hand, if minimizing estate taxes is a consideration, estate planning may have as a goal the reduction of the estate tax through the use of gifts, the marital deduction, trusts and the proper arrangement and ownership of insurance and your business organization. For purposes of this article, we will assume that your estate-planning objectives include at least the following two objectives: 1) the disposition of your property, at death, according to your wishes; and 2) the minimization or avoidance of death taxes and to the extent that estate taxes cannot be avoided, planning to ensure proper liquidity in your estate for the purpose of paying death taxes.

The following discussion is intended to highlight many of the more important factors that should be considered in the planning of any person's estate. Please bear in mind, however, that it is by no means a complete discussion of the estate-planning process.

Disposition of property at death

There are several different ways in which your property can pass at death. These include intestacy (dying without a will), disposition by will and disposition by "non-probate transfers" taking effect at death.

Intestacy—The primary reason to plan your estate is to accomplish the object of passing your property according to your wishes. If you die intestate (leaving no will), your property passes according to Colorado law. A brief review of the intestacy law reveals its shortcomings. For example, in most situations, if you die leaving a spouse and children, your spouse takes the first $25,000 of your probate estate and the balance is split equally, half to your spouse and half, outright, to your children. However, in most situations, a person wishes to pass all of the probate estate first to the surviving spouse or, if there is no surviving spouse, then to the children. As you can see, this does not take place under Colorado law; thus a will is necessary to pass your property according to your wishes.

Wills— The fundamental purpose of a will is to permit you to control the disposition, in writing, of your property at death. In this sense, having a will avoids the arbitrary application of our laws of intestacy and allows you, rather than the state of Colorado, to determine who receives your property at your death.

A simple will distributes all assets outright. Usually, the surviving spouse receives all such property and if there is no surviving spouse, the children receive the property outright, in equal shares. This type of will is normally sufficient if estate tax savings are not a concern because of the size of the estate and if the potential recipients of the property will be able to manage it properly.

A will with a contingent trust is often used when the estate is not large enough to require estate tax planning, but the children are too young to receive property outright if both parents die. Thus, the will with a contingent trust normally leaves everything outright to the surviving spouse, and if there is no surviving spouse, then in trust for the children. In summary, a will with a contingent trust is often advisable for young families with small estates and young children.

Another type of will often referred to as a "marital deduction/family trust will" creates trusts which come into existence at one's death. The primary purpose of these trusts is to minimize estate taxes.

Non-probate property transfers

A will is intended to dispose of one's "probate property." However, in many, if not most estates, probate assets constitute a small portion of a person's estate. The bulk of most estates pass not by the laws of intestacy nor by wills but by operation of law or by contract. Common forms or types of the "non-probate" property include life insurance, retirement benefits, joint tenancy and living trusts.

Life insurance—Life insurance proceeds pass directly to the beneficiary named in the policy. Consequently, it is imperative that all aspects of your life insurance be carefully coordinated with your overall estate plan, including any wills or trusts prepared by your attorney. Thus, it is very important that your attorney and insurance advisor work in concert to achieve your overall estate planning objectives.

Retirement benefits—Under most employee benefit plans established by an employer, the employee is entitled to designate the beneficiary of his retirement plan proceeds in the event of his or her death before retirement. Like life insurance, it is very important to coordinate the beneficiary provisions of your retirement plan with the rest of the estate plan. Unlike life insurance, there are other tax considerations involved in the designation of the beneficiary of the retirement plan proceeds.

Joint Tenancy—Owning property with another person as "joint tenants with right of survivorship" is one of the most commonly-used forms of ownership. It passes the property directly to the remaining joint tenant upon your death and does so without

the need for probate.

Living Trusts—Trusts are undoubtedly the most flexible and one of the most useful tools used in estate planning. A trust is an arrangement by which a "trustee" holds legal title to property for the benefit of one or more persons known as "beneficiaries". Trusts created by your will are known as testamentary trusts and do not take effect until death. A living trust or *inter vivos* trust is established during your lifetime. In either case, the trust provisions contained in the trust document govern how any property placed in trust is to be administered and managed by the trustee, and distributed to the beneficiaries.

The subject of trusts can be exceedingly complex and the operation of trusts can be difficult to understand. Nevertheless, trusts are extremely useful in the construction of an overall estate plan. The principal purpose of a trust must be to provide for a beneficiary or beneficiaries. Secondly, and only secondly, trusts can be used to minimize or avoid estate and income taxes. A third purpose for establishing a living trust is to avoid probate.

Estate Taxation

Estate taxes are death taxes. The amount of the tax is based upon the size of your estate and, like income taxes, they are progressive in nature. Earlier, we described many different methods of disposing of your estate; by intestacy, by will and by nonprobate transfers. For estate tax purposes, however, all of the assets passing by these methods are generally considered as part of the estate. For example, although life insurance owned by you on your life is a nonprobate asset, it is part of your estate for estate tax purposes and all the proceeds will be included in your estate, again for estate tax purposes, although the proceeds may pass directly to a spouse, children or a trust. In addition, your estate for tax purposes, known as your "gross estate", will usually include all your other assets, such as your home, other real estate, bank accounts, certificates of deposit, money market funds, stocks, bonds, interests in partnerships, your business and miscellaneous assets.

To determine the amount of estate taxes, you must first determine the size of your gross estate and then reduce the gross estate by your debts, casualty losses during estate administration not compensated by insurance, administration expenses incurred during the administration of your estate and funeral expenses. Any charitable bequests or contributions also serve to reduce the size of your gross estate. The two largest deductions which may be available to your estate are the "marital deduction" and the "exemption equivalent" (actually a tax credit).

The marital deduction—The marital deduction is a deduction the estate is entitled to for property passing to a surviving spouse. Prior to January 1, 1982, the marital deduction was limited to a maximum of 50 percent of the estate after debts and expenses or $250,000, whichever was larger. Under the new law, known as the Economic Recovery Tax Act of 1981, the marital deduction is unlimited. As a result, you can pass your entire estate to your surviving spouse, no matter what its size, and pay no estate taxes. However, any property qualifying for the marital deduction must be included in the estate of your surviving spouse at his or her death. When the total amount of estate taxes are considered, both at your death and at the death of your surviving spouse, the combined total tax may be greater than you anticipated.

The exemption equivalent—Most decedents' estates are entitled to a "unified credit" which exempts a portion of their estate from estate taxation. It operates much like the standard deduction available on your income tax return. Under recent changes in the estate tax law, the unified credit is increasing every year until 1987. As a result, an estate that is valued at less than $325,000 will not be subject to estate taxes in 1984. The estate of a person dying in 1987 or later, will not be subject to estate taxes if the estate is less than $600,000. It is these amounts which can also be placed in a family trust for the benefit of a surviving spouse, and children if so desired, without causing inclusion of that amount in the surviving spouse's estate at his or her death.

Estate taxation — planning opportunities

Planning to avoid or minimize estate taxes generally falls into three categories; the proper use of the marital deduction and exemption equivalent; reducing or "freezing" the size of your estate during your lifetime; and gifts to qualified charities during your lifetime or at the time of death. Because charitable bequests are beyond the scope of this article, we will discuss only the first two options.

Use of the marital deduction and exemption equivalent—Clients often ask if it is still necessary to engage in extensive estate planning since tax laws now permit a spouse to leave his or her entire estate to the surviving spouse without any estate taxes. However, especially in larger estates, it may in fact be disadvantageous to take advantage of the 100 percent marital deduction. Instead, it may be more prudent to leave less than the full marital deduction to the surviving spouse, in cases in which even a lesser marital deduction would eliminate any estate taxes payable at death.

When the surviving spouse dies, the amount of any property transferred pursuant to the marital deduction will be included in the surviving spouse's taxable estate. Assuming that no remarriage takes place, the surviving spouse's estate will not have the marital deduction available to reduce or eliminate estate taxes. In most situations, the only significant deduction will be the exemption equivalent. Thus, instead of using the 100 percent marital deduction, it may be less expensive to fund a family trust, at the first spouse's death, with an amount equal to the first spouse's exemption equivalent.

The family trust can be drafted to give substantial benefits to the surviving spouse for the rest of his or her lifetime. This includes the right to all the income for life, as well as principal, if needed, to continue to support the surviving spouse in his or her accustomed standard of living. The amount of the exemption equivalent placed in the family trust at the first spouse's death can not be included in the taxable estate of the surviving spouse at his or her death.

Reducing or freezing the estate during your lifetime—Perhaps the most obvious method of reducing estate taxes at death is to reduce the size of

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Preliminary Program
1984 CMS/CMSA Annual Meeting
September 20-22, 1984
Marriott Mark — Vail, Colorado

Wednesday, September 19

4:00 pm – 6:30 pm	Registration
6:30 pm	Welcome Reception Hosted by Marriott Mark

Thursday, September 20

7:00 am	Registration
7:00 am	Prayer Breakfast
8:00 am – 5:00 pm	CMSA Hospitality Area and Country Store
8:00 am – Noon	House of Delegates (CFMC Corporate Meeting)
9:00 am – 12:30 pm	CMSA Tour
Noon	Reference Committee Chairmen Luncheon
Noon	CMS Past President's Luncheon
1:15 pm – 3:15 pm	CMSA Mixed Tennis Tournament
1:30 pm	Reference Committee Hearings
3:30 pm – 5:00 pm	CMSA County Presidents/ President-elects
4:00 pm	Exhibits Open
4:30 pm – 6:30 pm	Exhibitors' Reception in Exhibit Area
6:00 pm – 7:30 pm	CMSA Reception

Friday, September 21

7:00 am	Registration
8:00 am – 4:30 pm	Exhibits
8:00 am – 5:30 pm	CMSA Hospitality Area and County Store
8:00 am – 3:00 pm	Scientific Program
8:00 am – 9:00 am	(Keynote) Futurism/Medical Economics
9:00 am – 10:00 am	Government Viewpoint
10:00 am – 10:30 am	Break (exhibit area)
10:30 am – Noon	Other Key Viewpoints (Panel) • Business and Industry • Medical Insurance Carriers • HMOs/PPOs/IPAs
11:45 am – 1:00 pm	COMPAC Luncheon
1:00 pm – 2:00 pm	"Motivational" Presentation Sponsored by CMSA
2:00 pm – 3:00 pm	Wrap up/Conclusions/Future Directions
6:30 pm	Presidents' Reception
8:00 pm	Presidents' Dinner

Saturday, September 22

8:00 am – 3:00 pm	CMSA Hospitality Area and Country Store
8:00 am	Registration
8:00 am – Noon	Exhibits
8:30 am	CMSA Open Board Meeting
8:30 am – 11:00 am	Scientific Program— (Three Concurrent Sessions) • Ethics Workshop • Future of Computers in Medicine (medical, not business application) • Recent Scientific Investigations of the Shroud of Turin (John Jackson, Ph.D., Vice-President, Shroud of Turin Research Project)
10:00 am	CMSA General Membership Meeting (Installation of Officers)
Noon	CMSA Annual Luncheon
1:30 pm	House of Delegates
2:00 pm	CMSA Incoming Board of Directors Meeting

/our estate during your lifetime. Perhaps the most involved, yet effective area of estate planning centers around the reduction of the size of your taxable estate through lifetime transfers.

Outright gifts—To reduce the size of your estate for tax purposes, you can make gifts to your spouse, children or other people. Gifts between spouses are tax-free.

Irrevocable life insurance trust—An irrevocable life insurance trust can be a most valuable estate tax-saving tool. This trust is established during your lifetime and becomes the owner and beneficiary of life insurance policies insuring your life. The distribution portions of this trust normally are quite similar to the family trust created under a will or revocable living trust in that your spouse and children typically are the beneficiaries. If you live more than three years after the transfer of life insurance policies to the irrevocable life insurance trust, the proceeds from those policies will not be part of your taxable estate. The proceeds will be invested instead and used for your spouse and children. The balance of the proceeds will escape estate taxation when your spouse dies and may be used to pay any estate taxes in your spouse's estate. The balance will pass to your children tax-free.

Freezing the value of property—Through the use of partnership freezes or corporate recapitalization, the value of your business or property interests can be frozen. The purpose of freezing the value is to avoid further appreciation in value which later will be taxed at your death. The appreciation normally is shifted from one person to another, usually from a parent to a child or children who may continue in the family-run business. In the proper situation, these techniques can be immensely useful in preventing an increase in the size of your estate, while allowing you to retain control of the frozen assets for the rest of your life.

Estate planning may involve a variety of other techniques, including minors' trusts, Clifford trusts, family partnerships, private annuities, installment sales, buy/sell agreements, charitable remainder trusts, charitable lead trusts and a host of other techniques and methods.

Updating your will or trust

An existing will or trust may be appropriate for your needs or may need updating. If the will or trust was drafted in another state, you may gain advantages by updating the document for Colorado laws. You also may need to update your will for tax reasons. For example, the "marital formula" in your marital deduction will may be outdated if your will was signed before September 13, 1981. In fact, the old marital formula may cost your estate more taxes than necessary if the formula is not revised.

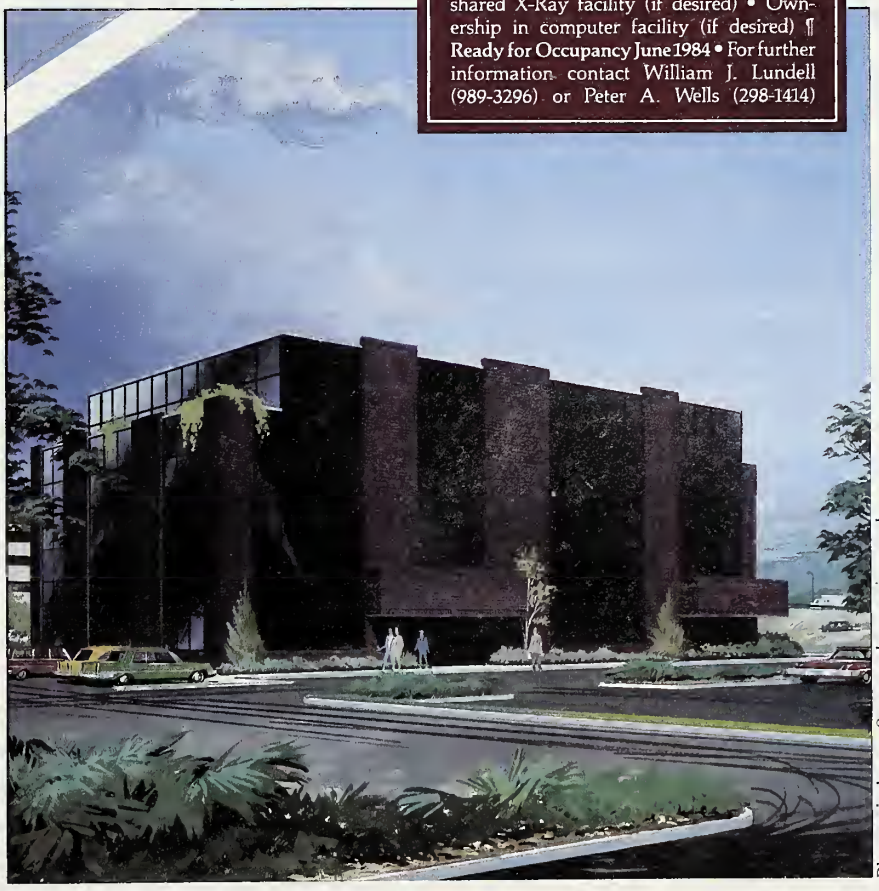
Your estate planning documents are among your most important legal documents. They represent an expression of your concern for your survivors, whether they be children, spouse, other relatives or charities.

This article necessarily has been very general. It is not intended to serve as tax or legal advice. Each estate planning situation is different and you should consult your estate planning attorney about your particular estate plan.

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Drug Therapy Q & A

This column is designed to provide Colorado physicians with specific answers to commonly asked questions about drug therapy. The column is prepared by the Rocky Mountain Drug Consultation Center in Denver. All questions published in the column were generated from calls received by the Rocky Mountain Drug Consultation Center. These calls came from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver Metro area or 1-800-322-6475 in Colorado for specific answers to any drug therapy questions. The center is open from 8 a.m. to 5 p.m. Monday through Friday, with 24 hour on-call service. The director of the center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine at the University of Colorado Health Sciences Center. The medical director is Earl Sutherland, M.D., Ph.D., Assistant of Medicine at UCHSC.

Both of this month's topics were written by Cynthia J.R. Gelman, B.S., R.Ph.

Digoxin—False Positive Serum Levels in Neonates

Request

Why is digoxin serum level monitoring of questionable value in the neonate:

Response

Studies in pregnant women [1,2] and in adults with renal impairment [3] who were not receiving digoxin have demonstrated false positive digoxin values on many serum assays. This phenomenon has also been demonstrated to occur commonly in neonatal patients.

Valdes et al [4] measured the apparent concentrations of digoxin in the plasma of 135 newborns 2-4 days of age who had not received digoxin using four different digoxin radioimmunoassays. Regardless of which assay was utilized, the majority of samples contained material that reacted as digoxin (digoxin-like immunoreactive substance; DLIS). The authors also prospectively followed 12 newborn infants who had never received digoxin. Plasma samples for each baby were measured with the same assay to prevent interassay variation. The values for DLIS tended to rise from birth, peak within the first few days of life, and decrease slowly thereafter. Assessment of individual DLIS was also analyzed in 63 babies [5]. There was little within-day variation; however, prominent day-to-day variation occurred, with maximum variation appearing 4-6 days after birth and then declining. DLIS has been shown to be present in infants up to two months [5] or six months [6] of age.

It has been speculated that DLIS may be coming from the fetal adrenal cortex since involution of the fetal adrenal cortex coincided with peak concentrations of DLIS and there is some similarity between the structure of digoxin and adrenal cortecosteroids [7]. However, a recent study compared the day to day variation of DLIS and dehydroepiandosterone and found no relationship between the concentrations of the two [5].

The degree of DLIS activity appears to be dependent on the specificity of the antibody. Pudek et al [5] utilized seven different immunoassay kits to measure the degree of interference of DLIS in neonatal serum. The seven immunoassay kits included NML., New England Nuclear, Becton Dickinson Immunodiagnostics, Serono Laboratories Inc., Clinical Assays, and Syva Co (EMIT). Results indicated spurious mean values for DLIS to decrease in the following order: NML greater than New England Nuclear; greater than Bio-Rad; greater than Clinical Assays; greater than Becton Dickinson; greater than Serono; greater than Syva. Differences in the degree of sensitivity were also demonstrated between different NML antisera lots.

Although it has previously been recommended that digoxin be measured in serum prior to administration of digoxin in the neonate [7], the results of the study by Pudek et al [5] indicating lot-to-lot variability as well as day-to-day variation in levels of DLIS would preclude the reliability of this method of measurement.

Conclusion

The serum of neonates not receiving digoxin may contain a digoxin-like immunoreactive substance (DLIS) which confounds measurement of therapeutic serum levels in neonates who receive digoxin. Recent studies also demonstrate lot-to-lot variability with immunoassay kits and day-to-day variation in DLIS levels appear to preclude serum measurement prior to administration of digoxin to obtain a base-line level.

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3. Graves SW, Brown B. Valdes R. An endogenous digoxin-like substance in patients with renal impairment. Ann Intern Med 1983;99:604-8.

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Pseudomonas Aeruginosa Infection Associated With Hot Tubs

Patient Data

Patient has a pseudomonas rash which occurred following use of a hot tub. What is the drug of choice to treat this patient?

Response

A variety of reports have described Pseudomonas aeruginosa infection from common exposure to hot tubs and water slides. Infections can occur in epidemics[1,7] or as isolated occurrences[8,9]. Pseudomonas aeruginosa serotypes 0:10;0:11,0:4 and 0:9 have been implicated.

In all cases reported, the onset of symptoms occurred from six hours to five days after exposure[1,6]. The predominant symptom is a papulovesicular rash. Lesions are on an erythematous base 2-5 mm in diameter with some pustular apices. The rash is typically present on the trunk, buttocks and proximal limbs. The face, neck, soles, palms and mucous membranes are usually spared. It is sometimes pruritic [8]. Associated symptoms of weakness, myalgia, chills, fever, headache, externalities, sore throat, enlarged axillary nodes, and tender breasts have also been described.

The infection appears self-limiting. There is no indication that antibiotic treatment, whether systemically or topically, is necessary or useful [8]. Most reports describe resolution of the rash within 10 days [1,3,9]. Patients with persistent rash or purulent otitis media were successfully treated with topical and IM or IV gentamicin, respectively [5,6,8].

Prevention of hot tub folliculitis can, in most cases, be achieved by following the guidelines from CDC for public spa and hot bath disinfection [10].

Conclusion

Hot tub folliculitis is a self-limiting infection. Rash and other associated symptoms generally resolve within 10 days. Persistent symptoms can be treated with gentamicin.

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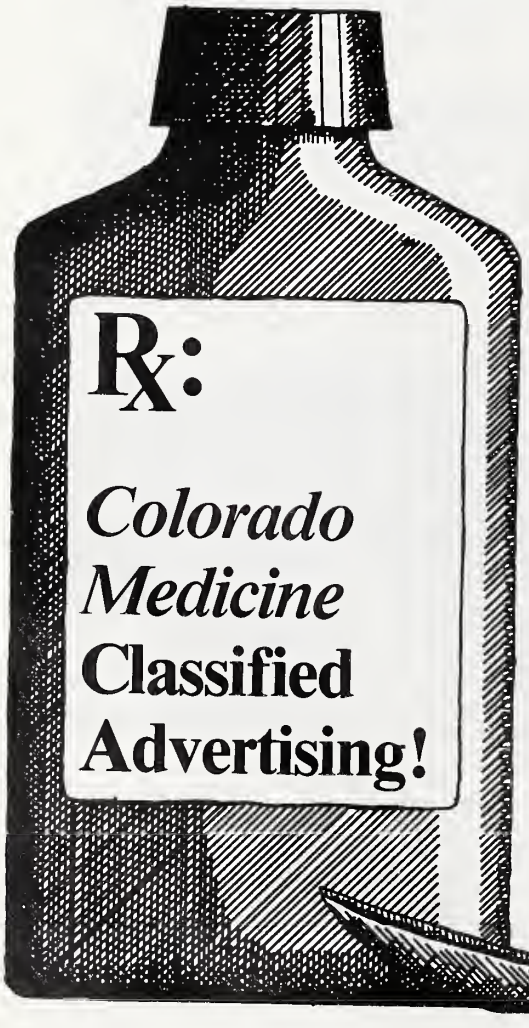
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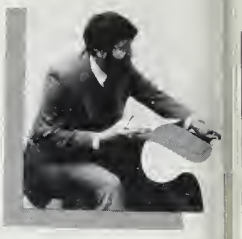
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colorado medicine



This Month's Cover:
This Month *Colorado Medicine* begins a series of articles about "the clinical frontier" in Colorado. New medical therapies, old medical techniques applied in new way, as well as new modes of practicing medicine will be explored in upcoming issues of the magazine. We inaugurate this series with an exploration of two topics, first, an interview with the medical director of Colorado's only physician-directed premenstrual syndrome clinic; the other, an interview with the director of Denver's first baromedical unit.

Also in this issue, John Whitesel, MD, President of CMS, discusses the accomplishments and role of CMS, past and present, in an examination of what the state medical society has meant to medicine and health care in Colorado.

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HEALTH SCIENCES LIBRARY

president's letter



John A. Whitesel, MD
President, Colorado Medical Society

The Unity, Versatility and Continuity of Our Medical Society

At the Interim Session of the Colorado Medical Society House of Delegates in March of this year, I spoke to your delegates about *unity* and how important this quality is to us when all of medicine faces adversity. Solidarity of purpose is our greatest weapon in promoting the ethics, standards and quality of medical care which we have understood and supported. These ethics, standards and quality of medical care have been developed by our predecessors over time after trial and error, through personal experience and sacrifice. Now our medical system is experiencing many changes. The forces of business, labor, government and consumers are effecting these changes based on the impetus of cost. We must maintain *unity* to repel changes which are destructive and acccept and promote those which will add positively to our present system.

Paradoxically, we are experiencing forces of change from within while being battered by those from without. These internal forces come from our own ranks, are being felt this year and will also be experienced in years to come. In this volatile atmosphere in which we find ourselves, we must develop a philosophy which promotes versatility for our medical societies, but maintains continuity and *unity*! This philosophy must not dismiss new ideas, but allow them to be carefully evaluated, debated and then selected or rejected. When such decisions are made together, we must support them together. This is the democratic process and is the cement for the bricks of *unity*.

CMS must maintain continuity and unity!

As illustrated to the Board of Directors at the June Board Meeting, we are a family. One doesn't always have one's way in a family, and one must occasionally give up personal desires or goals for the benefit of the family. With this philosophy, we can react positively to change or maintain concepts or portions of the present sytem which we feel are beneficial to modern-day medicine. With this philosophy, we can maintain the *unity* which is so vital to medicine today.

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guest editorial



John Buglewicz, MD
Chairman, Council on Professional Relations and Medical Service

DRGS: A Plot To Close Our Rural Hospitals?

1984 is the year that "Big Brother" government is appearing on the health care scene. Through DRGs and PROs, the Health Care Financing Administration (HCFA) will invade the staff rooms, surgical suites and patient charts of our nation's hospitals. In an attempt to control a predicted massive rise in health care costs, Congress has fallen upon a program that essentially has been untested outside of two states in the Eastern U.S. Even there, recent data has shown it to be less effective than had been desired.

But in this rush to do something to slow the tide of rising costs, Congress is doing by subterfuge what it cannot do openly, and that is to close many of the rural hospitals built over the past 30 years with Hill-Burton funds. Congress is doing so in the erroneous belief that closing such hospitals will save federal dollars and that providing quality health care will still be possible. The very patients about whom they profess to be most concerned are the ones who will suffer the most. For some years, in every rural health care council assessment, patient transportation, especially for the elderly, has been considered to be one of the major patient needs. If we now close these hospitals, as the government says must be done, the problem of transporting patients, and ultimately the problem of providing good health care, will be compounded.

Now if I were a bureaucrat who wanted to accomplish an unpopular goal, which could not be done directly, what whould I do? I would devise a scheme which would accomplish my goal in such a way that I would be declared a hero for saving taxpayers' dollars. I would also like to be able to lay the blame for any undesirable effects of my goal at the doorstep of the health care industry or hospital medical staffs and administration. In rural Colorado, as well as the rest of the country, this is exactly what DRGs are destined to do.

Despite the fact that perhaps 80 to 85 percent of the Medicare/Medicaid dollar is spent in the large ur-

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ban hospitals and 15 to 20 percent in the smaller rural hospitals, the latter will suffer the most. For the most part, these hospitals serve the rural elderly and poor. These are the very people to whom politicians refer as the most in need of health care. Close to 20 percent of the population of Fremont and Delta counties is over the age of 65, while in the state as a whole, the over-65 population is about nine to 10 percent. It is no wonder that the rural hospitals will run a Medicare/Medicaid ratio of patients at about 70 to 80 percent while larger urban hospitals will have about 35 to 40 percent of such patients at most.

What does this mean for the rural hospital? If present TEFRA payments allow only about 80 percent of the audited costs of health care to be reimbursed, then under DRGs, the estimated reimbursement is expected to be about 65-70 percent of costs. In a rural hospital of 35 to 40 beds with a 70 percent Medicare/Medicaid patient load, this would not only be an impossible situation, it would be a disaster that would soon lead to bankruptcy and closure. Thus would be accomplished exactly what Congress and the federal bureaucracy are after. That is, "unnecessary" hospital beds would be eliminated in areas in which the political impact is the least, in the sparsely-populated areas of the Western United States, where there are few votes and fewer Congressmen to raise objections.

Meanwhile, who will suffer the most? It will be the elderly and the rural poor who will have to travel 30 to 50 miles, if not more, for hospital care. Now why do I feel that there is a definite plan to make this happen? If Congress or HCFA were really concerned about this problem, it would be simple enough for someone to come up with a factor in the computation of DRG reimbursement to allow for an inordinate percentage of Medicare/Medicaid patient days. Not only has this not been done, but I have not read in any discussions of the program that such a plan has ever been considered.

Only through public education about the potential effects of this program on rural America can we bring pressure to bear on Congress and HCFA. Rural areas, like the inner cities, have a shortage of physicians. The way to solve this problem is not by limiting access to hospital care, but by expanding the role of the rural hospitals. These hospitals should provide more outpatient care, home and ambulatory care, preventive medicine and education. Eliminate these hospitals today and 15-20 years from now there will be another public outcry for "more accessibility" to health care in rural areas. We must protect what we have now, for the cost of replacing these hospitals in 15 years may be astronomical.

The solution to the health care cost "crisis" rests in the concept that made this country the great nation it is today. "Help those who cannot help themselves" but resist the temptation to buy votes with taxpayers' money by providing "free" care to those who can afford to care for themselves.

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the lobby



M. Robert Yakely, M.D., Chairman, Council on Legislation
Carol Tempest, Director, Government Affairs Division

Legislative Committee to Study Cost Containment

The 1984 legislative session formally ended on May 22 and the election year tactics have begun. Representative Chuck Heim (R), Colorado Springs, is added to the list of legislators not running for office and former Representative Steve Durham will try for that spot. Steve is a super friend of medicine and would be a good friend in the Senate. Lists of candidates are being finalized by both parties, and voting records are being tabulated.

We have a big summer and fall ahead of us both with a legislative interim study committee and a governor's health care project. The legislative interim committee has the following agenda and meeting dates:

The charge given the Legislative Interim Committee

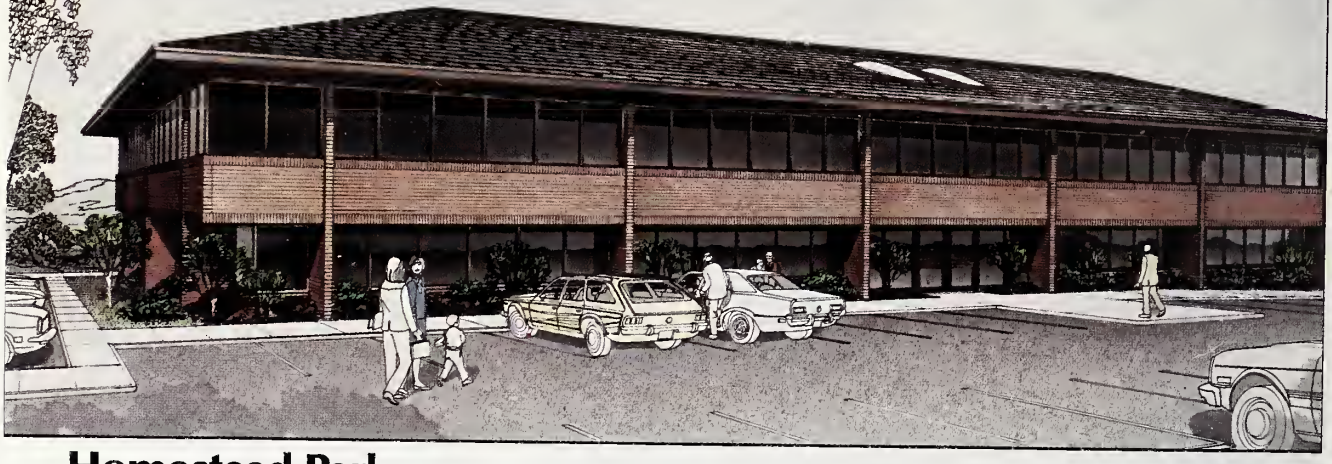
A study of medical cost containment:

a. Identify the problems of spiraling medical costs as they affect the private, as well as the public, sectors;

b. Evaluate alternative methods of ensuring that adequate medical services are available in the least expensive settings, including investigation of whether services are now being provided in acute care facilities could be provided in less expensive settings;

c. Evaluate alternative methods for health care financing and delivery, including, but without limitation, prepaid capitation of medical services and competitive bidding by providers of health care;

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d. Consider the impact of health insurance on medical costs and investigate means of reducing any impact which increases such costs;

e. Investigate alternative methods of funding the treatment of catastrophic illness;

f. Examine alternative methods of providing low cost health services, including independent practice by junior physicians, nurses, and other persons who have received short-term medical training;

g. Determine which medical services must be funded under Medicare and Medicaid regulations and which services are optional;

h. Examine legislation adopted by other states for the containment of medical costs and evalute its effectiveness;

i. Prepare and submit to the Legislative Council, based on the committee's deliberations, legislation which the committee believes will further the containment of medical costs in both the public and private sectors;

j. Investigate the extent of the powers and policy-making authority granted to the State Board of Social Services and the Department of Social Services by state law, including rule-making authority; the extent to which the state board and the department implement or administer programs under authority expressly or presumptively granted pursuant to federal law or rule or regulation; and whether state statutes and rules need to be updated to reflect the current policies and priorities of the General Assembly for such programs;

k. Examine the adequacy of county social services department procedures for determining eligibility for programs which involve medical assistance, including inquiries into applicants' divestiture of their assets by the use of living trusts and other methods.

Committee Meeting Dates: Thursdays, June 7 and 28, July 12, August 2 and 30, and September 27.

The committee makeup is:
Rep. Ronald Strahle, Chairman - (R), Ft. Collins
Sen. Cliff Dodge, Vice-Chairman - (R), Denver
Sen. Robert Allshouse - (R), Aurora
Sen. Dennis Gallagher - (D), Denver
Sen. Claire Traylor - (R), Wheat Ridge
Rep. Bill Artist - (R), Greeley
Rep. Ron Burkhardt - (D), Northglenn
Rep. Stan Johnson - (D), Pueblo
Rep. Phil Pankey - (R), Littleton

Sister Mary Andrew
Mr. Clark Ewald
Mr. F. Charles Foelicher
Mr. Francis Miller
Mr. Rex L. Morgan
Dr. H. J. Scarinzi

And the governor's agenda is as follows:

- Remove legal barriers to formation of PPOs;
- Require hospital (and MD?) rates to be made public;
- Data collection system (facility-based);
- Regulations/legislation to promote HMO enrollment;
- Require companies to offer HMO coverage; the state would subsidize HMO premiums;
- Review licensing criteria for MDs
  a. remove certain licensures;
  b. limit medical school enrollment and ask professional associations to set quotas;
  c. reduce student subsidies;
- Eliminate tax credit for capital financing;
- Mandatory technological assessment prior to marketing;
- Define medical ethics;
- Remove legal barriers to cost-containment initiatives of health insurance, providers and purchasers.

Governor Lamm has asked three of his department heads to implement his program. The three are: Dr. Tom Vernon, Department of Health; Dr. Frank Traylor, Department of Institutions; and Dr. George Goldstein, Department of Social Services.

So believe that it becomes very important that you take part in political campaigns and election year activities. Much of the work listed above will appear as proposed legislation.

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auxiliary report



Malpractice Suits: Trauma for Physician and Family

A malpractice suit can be a devastating experience for a physician and his or her family. Facing a suit is difficult under the best of circumstances. Many times, physicians react to being sued by denial, depression, anger or desperation. These reactions are not abnormal, according to Dr. David Pent of Phoenix, Arizona. Dr. Pent adds that physicians should recognize these reactions for what they are, because any one of them can interfere with the preparation of a good defense. In most cases, he says, the physician is completely unprepared because, "physicians are brainwashed throughout training that they never make mistakes."

The law, however, recognizes that everyone can and does make mistakes, and that responsibility for these mistakes is a form of liability.

Physicans learn throughout their training to look for, diagnose and treat the unexpected, the complications, the untoward in their practices. They prepare themselves and their families for possible chronic disease, terminal illness and the potential of being disabled, and they have insurance against the same.

Being financially prepared for litigation should be considered a cost of doing business. Having adequate insurance is a necessity today, as it relieves financial anxiety. Psychological reassurance can be more difficult to obtain, and it is something you can't always buy.

The family of a physician, particularly the spouse, must share some of the emotional trauma in a crisis. Yet, the medical family is so unprepared to deal with the psychological upheaval created by a malpractice suit. The physician, in his attempt to protect his family from a suit (be it just or unjust), may hamper his own practice of medicine. However much the physician may attempt to deal alone with such a crisis, it can't be done. Such a crisis may well cause malpractice incidents to occur; it may interfere with the physician's preparing a good defense; it can compel him to treat his lawyer as an adversary rather than someone who is defending him.

The physician's family is the best source of psychological assurance. How? Make the family members aware of the potential risks of your profession. Explain to them how malpractice incidents arise. Explain to them your responsibilities in such a situation. Share with them the emotional requirements of the circumstances.

The CMS Auxiliary has published and distributed a booklet entitled "Understanding Malpractice Claims." This booklet contains information covering the initiation of a malpractice suit, depositions, settlements, Colorado law, statute of limitations, etc. If possible, I believe a program of education should be developed, both at the medical school level and after, about professional liability, how we can prepare ourselves against the fear of the unknown and how physician and family can deal with the wrenching psychological effects of the malpractice suit. As a start, if you (physician or spouse) have not received one of the booklets, "Understanding Malpractice Claims," contact the auxiliary office at CMS (303-321-8590) and let's get started helping one another.

letters to the editor

Nix to Physicians' Unions

Dear Sirs:

I read with interest the short but well-written editorial by Dr. Donald Parsons in the March issue regarding the economic issue facing Colorado physicians. While there are obviously no easy solutions to the increasingly complex problems surrounding the control of the health care dollar, I was particularly appalled by the reference to one possible solution; namely, the establishment of a physician union.

It seems to me that the evils of collective bargaining as it relates to health care expenditures ought to be self-evident. I don't think we as physicians need to further estrange ourselves by seeking old solutions to a modern problem. Rather, I believe that our medical society should join hands with the other social agencies who have become necessarily involved in this issue; specifically, the government, business and labor. I believe that these other social institutions are far more concerned about their economic survival than they are about how medicine should be practiced, which they would, I am sure, rather leave to us.

Forming unions would, in my opinion, serve only our own economic interest, and would ignore the other players in the scenario. I believe in the true interest of the health of the nation that our social obligation extends to them as well.

Sincerely yours,
Richard L. Steig, MD
Medical Director
Boulder Pain Control Center



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We also believe that medical societies have certain tasks that the individual physician couldn't possibly assume — and shouldn't have to.

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To influence policies of organized medicine with which you disagree, we provide the means to have your views heard and respected.

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Governor's Family Fitness Day

The Governor's Council on Health Promotion and Physical Fitness is sponsoring the Second Annual Governor's Family Fitness Day to be held in Winter Park on Saturday, August 4 from 10 a.m. to 3:30 p.m. Scheduled events will include the 10 Kilometer Volksmarch (walk), 45 and 70 Kilometer Bicycle Tours, 10 Kilometer Cross Country Championships (runs) and one mile Fun Run. In addition to the fitness events, seminars and exhibits about health and fitness will be offered throughout the day.

For more information, contact Bill Wildberger, Chairman of the Family Fitness Day Committee, 866-2471.

National Biomedical Ethics Conference to be Held in Vail

The needs and problems facing institutions and others who care for handicapped infants will be the primary focus of a biomedical ethics conference to be held at the Westin Hotel in Vail August 8-11.

The conference, titled "Ethics on the Front Lines of Medical Care," is sponsored by the Center for Applied Biomedical Ethics at Rose Medical Center in Denver; the American Society of Law & Medicine; and the American Academy of Pediatrics.

The purpose of the conference is to provide physicians, administrators, nurses, social workers, clergy and concerned citizens with practical guidance on the establishment of ethics committees in connection with the problems of handicapped infants.

Special attention will be given to the American Academy of Pediatrics guidelines on infant bioethics committees, the legal issues accompanying the formation of an ethics committee, and the alternatives and resources available to families.

Key agenda items for the conference are "Decision Making for Severely Handicapped Infants: The Role of Family, Health Care Professionals and the State," "The Three Functions of Institutional Policy, and Case Consultation," "Practical Problems and Suggestions: Institutional and Infant Bioethics Committees," and "Medical Ethical Issues."

Conference co-chairmen for the meeting are Fredrick R. Abrams, MD, Director of the Center for Applied Biomedical Ethics and Rose Medical Center and Ronald E. Cranford, MD, Assistant Professor of Neurology, University of Minnesota School of Medicine, Minneapolis, Minnesota.

For more information, call 320-2500.

Longmont Hospital Dedicates Wing to Bill Fowler

The board of directors and the medical staff of Longmont United Hospital recently announced plans to dedicate the new outpatient surgical wing to the late William Fowler, MD. Dr. Fowler, a Longmont surgeon and member of the Boulder and Colorado Medical Societies, died last year of cancer.

The announcement was made by Kenneth Huey, hospital administrator, following the presentation of an oil portrait of Dr. Fowler. The portrait was commissioned by Dr. Fowler's widow, Jerri, who donated it to the hospital to hang in the lobby of the new west wing when it is completed.

Construction on the wing is expected to begin this summer. The construction of the new surgical department marks the initial phase of a $25-million, long-term expansion program for Longmont United Hospital.

Dr. Fowler, born near Eads and raised in Denver, was a 1943 graduate of the University of Colorado School of Medicine.

In 1944 he entered the United States Army as a first lieutenant and medical officer, serving in the southwest and western Pacific. In 1947, he entered medical practice as a family physician. He had continued as a member of the Colorado Air National Guard and in 1950 was called back into service for the Korean War. He served as commanding officer of the Clovis Air Force Base Hospital in New Mexico. He left the service as a lieutenant colonel in 1952.

After his discharge, Dr. Fowler took additional training to become a surgeon and spent four years at the Veterans' Administration Hospital in Denver. In 1957 he moved to Longmont and established his surgical practice. In 1962, he joined the staff of the Longmont Clinic, where he practiced for 20 years until his retirement in June, 1982. Dr. Fowler died April 2, 1983, 10 months following his retirement.

He was a Fellow of the American College of Surgeons. During his medical career, Dr. Fowler served as president of the Longmont Clinic, the Longmont United Hospital staff and the Colorado Chapter of the American College of Surgeons, the Boulder County Medical Society and the Boulder County Tuberculosis Association.

Dr. Fowler was married in 1972 to Geraldine ("Jerri") Greer of Limon.

Shortly after his death, Mrs. Fowler established the Dr. William G. Fowler Memorial Scholarship Fund, which will award its first $500 scholarship this spring. Eligibility will be determined by academic achievement or financial need. Applicants must reside in Boulder County and must have completed two or more years as a student in the health sciences.

Inquiries can be directed to Scholarship Fund, P.O. Box 814, Longmont, 80501. Applications are available at First National Bank, Longmont Clinic and Longmont United Hospital, or by sending a self-addressed, stamped envelope to the address above.



Jerri Fowler, shown with the portrait done of her late husband, Dr. William Fowler

Tick Alert

All hikers, campers and other outdoor enthusiasts in the mountains should stop for routine "tick checks" every few hours to prevent Colorado tick fever, according to a Colorado Health Department report.

An estimated 75 percent of all tick fever cases could be prevented if people in outdoor mountain environments periodically checked for ticks and removed them before they transmitted the disease, according to Ken Mesch of the Disease Control and Epidemiology Division.

The Rocky Mountain wood tick carries the virus causing tick fever. The tick season usually begins in the spring when

the weather warms up. However, the danger from ticks subsides as the summer advances. Late snow cover last year probably lowered the number of cases, to 116, the lowest since 1978, according to Mr. Mesch.

Larimer, Boulder, Jefferson and Gunnison counties have been heavily infested with infected ticks in past years. Ticks are most numerous on south-facing slopes with low bushy vegetation, but may be found up to timberline, according to Mr. Mesch.

He has developed a brochure called "Beware of Colorado Tick Fever " to educate outdoor enthusiasts about prevention of the disease. For further information about tick-borne illnesses, or for copies of the brochure, contact Ken Mesch at 320-8333, ext. 3112.

How Women Physicians' Practices Differ from Men's

Data recently released by the American Medical Association reveal that women constitute a growing proportion of the medical profession — and that proportion will continue to increase, because more women are entering the profession than ever before. From 1970 to 1981, the percentage of female physicans increased from 7.7 percent to 12.2 percent. Nearly 30 percent of today's medical students are women.

Career choice differences between female and male physicians can be noted in type of specialty, type of practice (self-employed or employed by others) and hours of work each week. On the average, the number of patient visits each week and both annual and hourly income rates for female and male physicans differ as well, according to the AMA 1982 survey data.

While female physicians constitute 12.2 percent of all physicians in 1982, they comprised smaller percentages of general/family practitioners (8.9 percent) and surgeons (5.6 percent) but larger percentages of medical and other specialists (15.4 percent and 15.1 percent respectively).

Female physicians were less likely to be self-employed than men; the share of self-employed female physicians was 26.4 percent smaller than that of male physicians. One factor causing this difference may be the relatively larger proportion of young women physicians. Physicians 40 years of age or younger, according to the AMA, tend to be self-employed less frequently. Another factor may be the comparatively easier and less costly effects of interrupting careers of young women physicians who take time off for child bearing and rearing.

The study states that female physicians averaged 7.9 fewer hours in practice each week than male physicians and saw 18.5 percent fewer patients on the average. These differences usually are not attributable to differences in specialty and age distribution. Among surgeons, however, hours worked by men and women physicians were nearly the same.

Female physicians, on the average, earn less from medical practice than male physicians. The average annual net income (income after expenses but before taxes) of male physicians in 1982 was $102,000, compared to $65,200 for female physicians; so women averaged 64 percent of the income of men. Part of the income differential is attributable to differences in hours practiced, specialty and the form of practice. However, when income per hour is calculated, women physicians in 1982 earned $30.10 per hour compared to $39.80 for men; or 75.6 percent of the men's average.

Since 1972, women physicians have had annual percentage increases in earnings slightly higher than men physicians. While the average annual percent of the increase in annual earnings for men physicians was 7.9 percent, women's earnings grew by an annual average of 9 percent. Average annual percent change in income per hour was also larger for women physicians than for men, 6.8 percent and 6.2 percent respectively. Thus, says the report, it appears that the earnings differential between male and female physicians is closing slowly over time.

Survey data appear in the March, 1982 *SMS Report*, which reports on the Socioeconomic Monitoring System directed by the AMA Center for Health Policy Research and the AMA Division of Survey and Data Resources. The SMS surveys for the first through fourth quarters of 1983 contain a representative sample of 7,630 nonfederal physicans in patient care. Pooled response rate was 63 percent.

Epilepsy Association Sponsors Public Forum

"Life Support: Good or Bad, Who Will Pay?" is the subject of a public forum sponsored by the Colorado Epilepsy Association. The forum will be held Monday, July 16 at 7:30 pm at Montview Presbyterian Church, Dahlia and Montview Boulevard in Denver. The program, second in a two-part series, is being underwritten by First Interstate Bank of Denver.

Featured speakers and panel members include the Reverend Alex Lukens, Jr., Chaplain at Presbyterian Aurora Hospital; Frank Traylor, MD, Executive Director of the Department of Institutions and Fredrick Abrams, MD, Director of the Center for Applied Biomedical Ethics at Rose Medical Center.

The first program, "Principles That Give Form and Meaning to Life," which took place June 13, had Governor Richard Lamm as keynote speaker.

Dr. Gerald Rainer, President-elect of CMS, also spoke at that forum.

Mary Jo Jacobs Receives "9 WHO CARE" Award

Mary Jo Jacobs, MD, of Glenwood Springs, is a 1984 recipient of the "9 WHO CARE" award sponsored by Channel 9. Dr. Jacobs was honored for her community service, including her work toward unified ambulance services for her area, a miners' registry and cancer registry, the Mountain Valley Developmental School for the Handicapped and the Senior Health Clinic. Dr. Jacobs also donates much time to her position as Public Health Officer for Garfield County.



Dr. Jacobs has long been an active member of her local and state medical societies. She is a member of the CMS House of Delegates and has been a member of several councils and committees.

She also received a Colorado Senate Tribute on May 21 from Senator Polly Baca for her volunteer service.

The "9 WHO CARE" program, now in its sixth year, was established by Channel 9 to honor outstanding volunteers in the state. Nominations are submitted by individuals and organizations from throughout Colorado. Selections are made by the "9 WHO CARE" Board of Governors, a panel of 29 prominent Colorado citizens which includes Frank McGlone, MD, founder of the Medical Care and Research Foundation, former Denver Mayor William McNichols, and Senator Baca.

The nine winners received $1000 in cash and a $1000 donation to the organization of their choice. Dr. Jacobs' award will go to Garfield Youth Services. The recipients of the award also received a sculpture, "The Prospector," created by artist Robert Koch.

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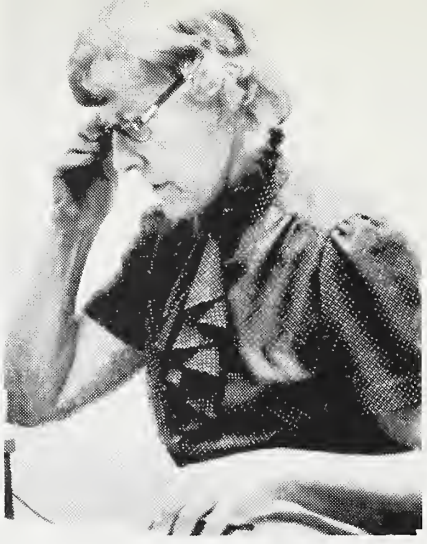
PMS: The Total Picture

Ed. Note: Dr. Mabel Brelje, a Denver obstetrician-gynecologist, is medical director of a clinic that specializes in the treatment of premenstrual syndrome. The clinic's approach is unusual in that it takes a holistic approach to the treatment of PMS, basing much of the therapy on nutrition and diet. The interview was written by Publications Editor, Sheila Swan.

PMS: Some women who suffer from it think they're going crazy. Some lose jobs because of it. Husbands, boyfriends, children, may bear the brunt of emotional tirades, without understanding what's going on. The symptoms include depression, irritability, headache, cramps, water retention, anxiety and lack of emotional control. Although PMS (premenstrual syndrome) has been around a long time, it has just begun to gain serious medical recognition. An estimated six million women in the United States may suffer from the syndrome.

In response to this problem, Mabel Brelje, M.D. and Jeanann Rowe, nurse practitioner, opened a clinic, Premenstrual Syndrome Consultants of Colorado. The clinic, which opened in September, 1982, is the second one of its kind in the United States. *The first clinic to specialize in PMS treatment in the U.S. was opened several years ago by Dr. Ron Morris. Dr. Morris studied with Dr. Katharina Dalton, the British physician who pioneered the use of natural progesterone for PMS treatment.


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(Although natural progesterone has been used to treat PMS for many years in England, its use for PMS treatment has not been approved in the United States by the Food and Drug Administration. However, it has been approved for other uses and thus can be legally prescribed.)

The clinic currently treats aproximately 900 patients. In June, Dr. Brelje and Ms. Rowe opened a new clinic, called "Total Living Complex." with Sol Grazzi, MD, a male family practitioner who specializes in a holistic health approach to medicine. PMS Consultants has been incorporated into the new family-treatment clinic.

Although Dr. Brelje does use progesterone for certain cases, she notes that these patients must exhibit a "classic set" of symptoms — and the effectiveness of other treatments must be ruled out. In Dr. Dalton's work, only about 18% of the patients qualified for progesterone therapy. "What about the other 80%? "questioned Dr. Brelje. The answer, she says now, was that "you had to look at the underlying problems." So Dr. Brelje, an OB/GYN by training, found she had to refer to her general medical training, as well as reading up on the major PMS studies.

As she took the medical histories of her patients, it became evident, she said, that "the immune system was probably the culprit. "Many of her patients already suffered from immunologically-related diseases, had allergies, food or chemical sensitivities. A number, in fact, either had alcohol problems or had a history of alcoholism in their families. Many women become sick, with migraines, flu and other illnesses, just before their periods. "There is something about the pre-menstrual phase that suppresses the immune system and therefore we have more illnesses." Dr. Brelje predicted that the immune system and its effects on the ovarian/endocrine system will become a major focus of PMS research. In fact, she said, much of the research taking place does indicate that PMS may be a product of a disorder in the immune system.

One study, by Dr. S.S.C. Yen, indicates that the causes of PMS may derive from an abnormality of the hypothalamic function, affecting the interrelationships of the endocrine system, immune system, neurological system and psychological systems. (Dr. Yen and Dr. R.L. Reid published a major article on PMS in the American Journal of Obstetrics and Gynecology in 1981; the next article, discussing what Dr. Yen believes to be four major causes of PMS, has not yet been published.)

Still other research, Dr. Brelje noted, indicates that many gynecological diseases, including toxemia of pregnancy, endometriosis, and some forms of dysmenorrhea, are diseases of the immune system with manifestations in the endocrine system.

Another study, she said, postulates that women build antibodies to their own thyroid hormone, and that it is these antibodies which may be one of the major causes of PMS. Additionally, she noted, an article in the November, 1983 issue of Science magazine, written jointly by physicians from three medical school pediatric departments, theorized that juvenile diabetics "have antibodies to their own insulin — and that is why they become diabetics." Thus juvenile diabetes may be another situation in which people develop antibodies to their own hormones and thus develop disease.

Dr. Brelje said that there is usually an event in the lives of women with PMS, "a major trauma in their lives," that precipitates the complex of symptoms called premenstrual syndrome. The event could be a surgery, birth, marriage, divorce, new job that, combined with other factors "creates a total stress load on the body." The psychological/physical stresses on the body have a cumulative effect; symptoms which may seem negligible for a number of months or years begin to occur more frequently. "When the situation becomes chronic, then they begin to realize they have a problem." she said.

Despite the medical community's caution on the subject, PMS has been greatly sensationalized by the mass media in recent months. PMS has also been used as "evidence" of women's biological inferiority in antifeminist arguments. Dr. Brelje pointed out that men, too, are subject to immunological disorders and may also suffer from food/chemical and environmental sensitivities. However, they do not have that "extra draw on the energy needs" in the hypothalamus, which may tip women "over the edge" during the eight to 10 days before menstruation, but they still have the same complex interrelationship of brain and glands. Thus, what may become an acute condition at certain times of the month for PMS sufferers, may be a chronic condition in men, Dr. Brelje noted.

Dr. Brelje acknowledged that the treatment of PMS is still very contro-

versial and that there is as yet no conclusive evidence of the causes. She commented that there is a "wide spectrum of possible etiological factors" taking place with PMS. Many physicians do not recognize PMS as a legitimate medical condition, and those who do, "are frustrated because they do not know how to treat it."

According to Dr. Brelje, some 40 percent of menstruating women may suffer from PMS and 10 percent of these are severely affected by it. Much more research is needed, she says, although she notes wryly "PMS research is not a high priority with federal government funding." She added. "We simply haven't the necessary data because not enough research has been done."

However, she believes that in another five years we will see some exciting results in the research and treatment of PMS, toxemia and other gynecological problems.

Dr. Brelje emphasized that before a diagnosis of PMS is made, the women who come to the clinic are thoroughly screened for possible other medical contitions and, if necessary, referred to other medical specialists for evaluation. Several hours are spent in evaluating patients before even beginning treatment, she said. Also, the clinic sponsors health education classes and support groups for its patients.

When other problems have been ruled out, then Dr. Brelje begins a close examination of her patient's diet and lifestyle. A major emphasis of the clinic's treatment is on nutrition. According to Dr. Brelje, vitamin B6 (a co-factor in many of the enzymatic reactions occurring in the body, "particularly the hypothalamus" and magnesium, "an essential mineral in enzymatic reactions" are critical to good nutrition for PMS patients.

Many of her patients have an "overload of candida albicans," Dr. Brelje said. She added that this yeast overload comes from two sources, from overproduction of yeast because of antibiotic therapy and from the overabundance of yeast in modern food products. According to studies, she noted, the problems from yeast come from the yeast toxin, which bind the estrogen receptor sites. No antibodies are built to the toxin, since the body does not recognize it as a foreign substance. So, "the only way we can address that problem is by removing the toxin from the environment," Dr. Brelje said. A patient may be advised to remove yeast-containing products from her diet and/or given Nystatin (in oral form, in order to remove the yeast from the patient's gastro-intestinal tract).

"About 50 percent of our patients," Dr. Brelje said, respond to the dietary/yeast treatment approach. Another 20 percent respond to the progesterone. That leaves another 25% who do not respond well to any of the aforementioned treatments. For those patients, Dr. Brelje looks at the other immune system. "We look at food and chemical sensitivities, and we're looking now at the auto-immune diseases," she commented. "PMS is a very broad problem, and that is why we in medicine have been frustrated... The same grouping of symptoms may present themselves, but with a different cause."

If the patient is experiencing a good deal of stress, then she may be referred for counseling or psychiatric therapy. It is also important to look at the patient's physical environment, Dr. Brelje believes, since allergic reactions may play a role in triggering PMS. Thus she asks patients about their homes and workplaces, e.g. to what kinds of dust, pollution, chemicals, etc. they may be exposed to in their daily lives.

Dr. Brelje acknowledges that most physicians take a sceptical view of the holistic approach to medicine, although that attitude may be changing as the interest grows in preventive medicine and educating the patients about wellness. A good deal of time is spent in educating the patients about nutrition and a healthier lifestyle at the clinic, with the aim of "teaching people to be responsible for their own health." At the new clinic, Dr. Brelje, Ms. Rowe and Dr. Grazzi will be treating families as well as women with PMS. Ideally, she would like to practice in a medical situation in which a "complex of physicians, each with different expertises," could work together for the total treatment and education of the patient.

*Ed. Note: Another PMS clinic, in Aurora, recently closed. The clinic's director, David Harris, MD. said the reasons for the closing were primarily financial. The costs of running such a clinic, he said, are very high, because the physician must spend a great deal of time with each patient. Dr. Harris, who used progesterone as well as a nutrition-based approach, still treats PMS patients with his OB/GYN practice.

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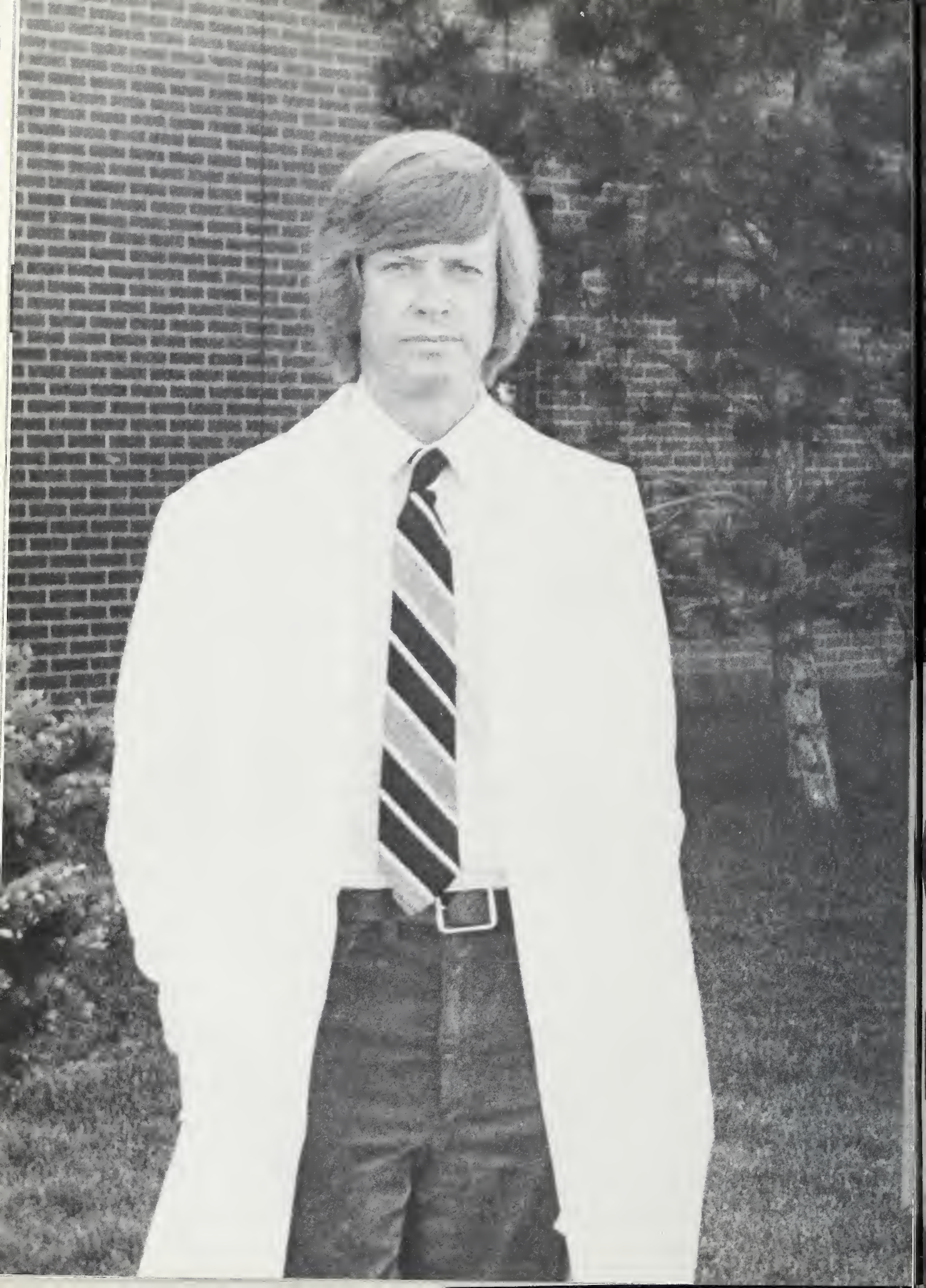
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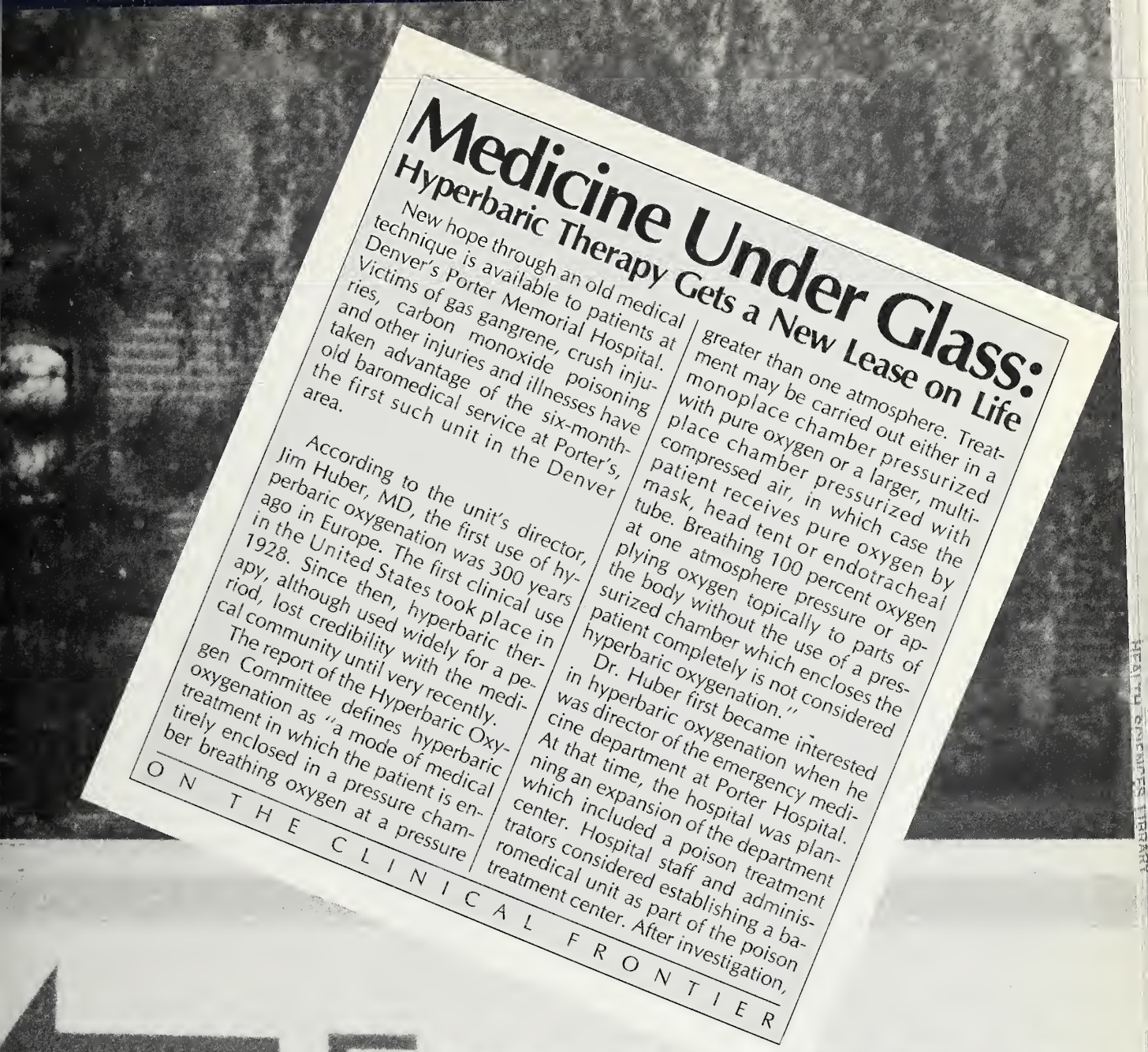
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Medicine Under Glass:

Hyperbaric Therapy Gets a New Lease on Life

New hope through an old medical technique is available to patients at Denver's Porter Memorial Hospital. Victims of gas gangrene, crush injuries, carbon monoxide poisoning and other injuries and illnesses have taken advantage of the six-month-old baromedical service at Porter's, the first such unit in the Denver area.

According to the unit's director, Jim Huber, MD, the first use of hyperbaric oxygenation was 300 years ago in Europe. The first clinical use in the United States took place in 1928. Since then, hyperbaric therapy, although used widely for a period, lost credibility with the medical community until very recently.

The report of the Hyperbaric Oxygen Committee defines hyperbaric oxygenation as "a mode of medical treatment in which the patient is entirely enclosed in a pressure chamber breathing oxygen at a pressure greater than one atmosphere. Treatment may be carried out either in a monoplace chamber pressurized with pure oxygen or a larger, multiplace chamber pressurized with compressed air, in which case the patient receives pure oxygen by mask, head tent or endotracheal tube. Breathing 100 percent oxygen at one atmosphere pressure or applying oxygen topically to parts of the body without the use of a pressurized chamber which encloses the patient completely is not considered hyperbaric oxygenation."

Dr. Huber first became interested in hyperbaric oxygenation when he was director of the emergency medicine department at Porter Hospital. At that time, the hospital was planning an expansion of the department which included a poison treatment center. Hospital staff and administrators considered establishing a baromedical unit as part of the poison treatment center. After investigation,

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it became apparent that there was a real need for a separate baromedical center. Dr. Huber then assumed charge of the new unit when it opened in November, 1983.

The new program has received such heavy use that a second HBO chamber was installed in early April. Dr. Huber said that more than 1,000 treatments have taken place for a toal of 75 patients.

During the 1930s, '40s and '50s, HBO therapy was used to treat many medical conditions, often inappropriately. Dr. Huber said, "I liken it (HBO therapy) to the use of penicillin," which at one time was considered a "cure-all" for many ills. Eventually, after much misuse of the therapy, the medical community came to regard hyperbaric oxygenation as dangerous or unproven therapy.

However, during this period when HBO therapy lost credibility, many studies were taking place which eventually were to establish it as viable medical treatment for certain conditions, Dr. Huber noted.

In the 1930s, hyperbaric oxygen was used in Navy studies to more rapidly decompress divers and to treat patients suffering from decompression sickness. During the 1950s and '60s, extensive research on oxygen tolerance was conducted as part of the space research program. Then, in 1967, the Undersea Medical Society was founded, according to its literature, "dedicated in support of man engaged in underseas activites." These activities, of course, included the special medical problems of divers, including decompression sickness.

In response to the confusion over hyperbaric oxygen therapy, the UMS took several actions "to help bring order to the field." First, in October, 1975, the society held a workshop at the University of California Medical Center in San Francisco. Fifty leaders in hyperbaric oxygen research and clinical practice participated in the workshop. The results of this meeting were published in a textbook, *Hyperbaric Oxygen Therapy,* edited by the chairmen, J.C. Davis, MD, and T.K. Hunt, MD.

The book established the "state-of-the-art" and divided the field of knowledge of baromedicine into "irrefutable fundamentals," "currently accepted indications" and "promising research areas."

Second, in November, 1976, the society established its Committee on Hyperbaric Oxygen. The committee presents an annual report on hyperbaric oxygen research and treatment.

Third, the society developed an information center to which the medical community can turn with questions on any aspect of hyperbaric oxygen therapy. Finally, in 1980, the society began publishing a quarterly journal of abstracts, *Hyperbaric Oxygen Review,* which includes review articles.

Today, Dr. Huber noted, hyperbaric oxygenation is "rational, scientific and proven" therapy for 12 disorders. They are:

- radiation necrosis of bone and soft tissue
- decompression therapy
- acute carbon monoxide poisoning
- gas embolism
- gas gangrene
- chronic refractory osteomyelitis
- mixed anaerobic/aerobic soft tissue infection
- crush injuries
- compromised skin flaps, grafts and chronic non-healing ulcers
- refractory mycoses
- acute cyanide poisoning
- acute cerebral edema
- acute blood loss anemia
- acute thermal burns

Hyperbaric oxygen therapy has been used for other diseases, but so far such treatment is considered investigational.

At Porter Hospital, in addition to Dr. Huber as full-time medical director, all the emergency physicians have been trained in hyperbaric medicine. Baromedical respiratory therapists are available 24 hours a day for treatment of patients. If a patient requires nursing care, emergency department nurses trained in hyperbaric medicine are available. A respiratory therapist is with the patients at all times during treatment. Also, a baromedically-trained physician is available should a patient need emergent compression or decompression, or should any life-threatening situation occur.

Three baromedical training courses are currently available in the U.S., Dr. Huber stated; one in Long Beach, California; in Milwaukee and in Baltimore. For the most part, the Porter staff have taken their training at the center in Long Beach. The five-day course includes theory and hands-on training.

Dr. Huber said that most patients respond well to the idea of hyperbaric oxygen treatment. Some experience "confinement anxiety" during their first treatment but usually are able to get used to the chamber. A

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microphone and two-way radio are hooked up to the sound-proof chamber, so patients are able to listen to tapes, talk with the doctor or respiratory therapist, or even watch tv. (Each chamber has a television within viewing distance.)

Length of treatment varies from 60 minutes to two hours. Frequency of treatments ranges from every six hours to once a day. Treatment may be done on an in- or out-patient basis.

Because the treatment is still considered controversial by many physicians, Dr. Huber held lectures and discussions on HBO therapy with all the physican groups at Porter's when the unit opened. He stressed the importance of all the physicans, as well as therapists and nurses, working as a team in the overall patient treatment. He noted that it has been a "tremendous educational process" for everyone involved in the project.

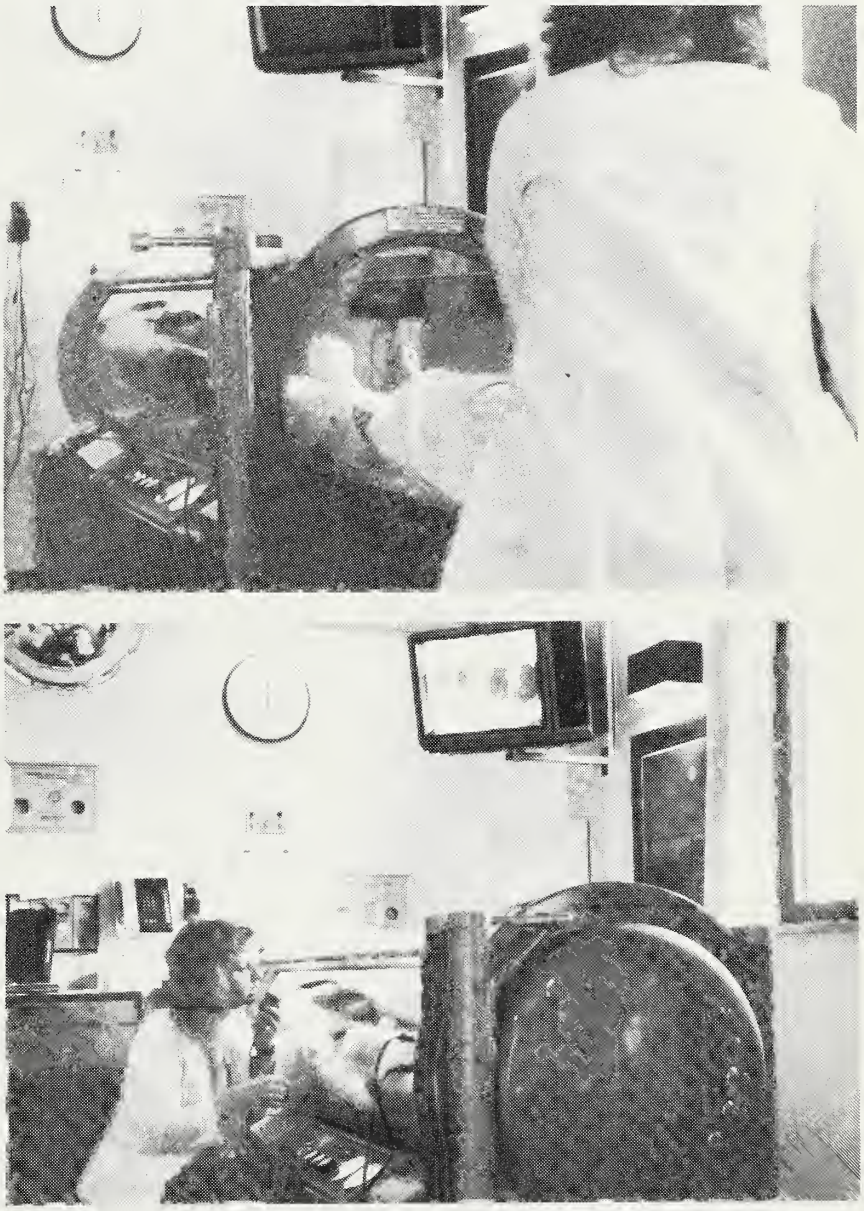
Since Porter Hospital opened its first baromedical chamber, St. Anthony's has established a hyperbaric oxygen chamber. Presbyterian/St. Luke's will also be opening a unit. Two other hyperbaric chambers are in operation in Colorado, one in Pueblo and one in Colorado Springs. In the eight-state region surrounding Colorado, Dr. Huber said, only two other chambers exist, one in Albuquerque, New Mexico and one in Salt Lake City, Utah. Hence, the center at Porter's receives many calls from physicians and hospitals across the country about hyperbaric oxygen therapy.

The hospital has a number of plans for the program. First, a new medical director will take over from Dr. Huber. He is Steve Thom, both an MD and a Ph.D. in microbiology, who is presently completing a two-year fellowship in hyperbaric oxygen therapy. He is the first and only person to complete such a fellowship, Dr. Huber pointed out. In addition to running the treatment center, Dr. Thom has received a faculty appointment to the University of Colorado. He will continue to do research in hyperbaric oxygen therapy. Dr. Huber will return to the practice of emergency medicine, but will also be associate medical director of the baromedical unit.

Other plans include establishing a baromedical training program in conjunction with the other hospitals in the metropolitan area with such units.

Porter's will sponsor the first Winter Symposium on Baromedicine, which will take place in Snowmass January 28-30, 1985. For information, call the baromedical unit at 778-5724.

The Eighth International Congress on Hyperbaric Medicine will take place in Long Beach August 20-22. The conference will include original papers, exhibits, poster presentations and plenary sessions. For information call (213) 595-3613. Finally, for those interested in the field of underseas medicine, a Rocky Mountain Regional Chapter of the Underseas Medical Society is being organized. Dr. Huber said that the UMS has 50 members in the State of Colorado. If it seems strange that a landlocked state would have so many physicans interested in underseas medicine, according to Dr. Huber, Colorado ranks second in the U.S. in per-capita number of deep-sea divers.



Cindy Coster, baromedical respiratory therapist, shown with a patient undergoing treatment. Each unit is equipped with two-way communication so the patient can talk with the doctor or therapist, as shown. Each chamber also has a television within viewing distance. The lighting is kept low to avoid siezure activity and to prevent deterioration of the plexiglass chamber.

CMS:

Successes, Problems and Solutions

by John A. Whitesel, M.D., President
Colorado Medical Society

Editor's Note: The following is a summary of the Colorado Medical Society in 1984, as presented by Dr. Whitesel to an Aurora-Adams County Medical Society general membership meeting.

I have been a member of the Colorado Medical Society for 21 years, but it was not until I became more actively involved in the system that I understood what the CMS is. . . and what it represents to physicians in Colorado.

I have learned that the single-most important aspect of the CMS for its members is organization. . . and that if this organization, created by the CMS, were not available to the physicians it would have to be developed!

Since its creation in September, 1871, the CMS has been the backbone of many medically related projects which are, after more than a century, still an integral part of medicine in Colorado and of benefit to all. For instance:

A. CMS was chiefly responsible for the establishment of the University of Colorado School of Medicine and, even after 100 years, remains active in a wide variety of school programs and departments.

B. It was the strength and wisdom of the Colorado Medical Society which brought public realization that hospitals were institutions for the ill to recover and not be isolated from the healthy. Our society continues to serve in the pivotal role of helping determine standards of care and treatment in public and private hospitals, extended care and long term care facilities.

C. CMS was instrumental in developing the ongoing public school health program. The CMS efforts to establish a statewide vaccination/inoculation program will benefit public health for generations to come.

D. Through its councils and committees, CMS has been the moving force behind establishing industrial medicine standards, providing for the protection of industrial workers and striving for quality in workmen's compensation law.

E. Because of the CMS Continuing Medical Education Accreditation Program, 50 percent of Colorado's hospitals provide continuing medical education to hospital medical staffs.

F. It was the Colorado Medical Society that first helped in the creation of the Colorado Medical Practice Act. Through CMS's Council on Legislation, your organization continues. . . every day. . . to protect that act from the numerous assaults by others who would tell you how to practice medicine.

Through this single, state-wide organization, physician members achieve a:

1. Grievance procedure to address differences.

2. Judicial Council to administer questions of ethics and organizational procedure.

3. Legislative representation not possible through individual means.

Public representation of the whole of medical practice.

5. Social interaction between physicians and among physicians and allied professionals.

6. Framework of education providing for maintenance of the state of the art.

7. Central reference body in the scientific, educational, legal, ethical, economic, political and regulatory arenas of medical practice.

8. Public health awareness which allows for changes in, or adaptation of, medical standards for the public in schools, in industry and in all aspects of life among the general populace.

Colorado Medical Society welds all these faces of medicine into a single force for the physician through communication, through state-wide listings for physician referrals, through socio-economic programs for the aid and protection of the individual practitioner (i.e., COPIC Trust professional liability insurance, CME accreditation, legislative process through the CMS committees, councils, board of directors and the House of Delegates), through the awareness by physician members for the good of fellow professionals, and is a staunch, single voice at the local, state and national level.

CMS is the one factor which prevents total fragmentation of "organized medicine."

During the current session of the Colorado General Assembly CMS members were represented in tort reform legislation placing a limit on damages for pain and suffering, and on punitive damages, and on a bill that would extend P.C. (Professional Corporation) liability to the individual. CMS represented you regarding the proposed sunset review of the Medical Practice Act, on the prompt payment bill, worked to authorize physicians to serve on county hospital boards, defeated the lay midwifery bill, defeated the Medicaid contracting bill, defeated the Medicare contracting bill, defeated the increase in wrongful death damages, represented your philosphy in the living will legislation, the medically indigent issue and the Medicaid decrease in conversion factors, the primary care physician program and the physician incentive pool.

You were represented in con-

trolled substance abuse legislation, in legislation to certify physician assistants, respiratory therapists, psychologists, optometrists, chiropractors, social workers, athletic trainers and physical therapists.

Your legislative representation included opposition to increasing state speed limits, passage of legislation to require child restraints in motor vehicles, defeat of the proposal which would allow hospitals to hire physicians as employees.

Through CMS, you have taken an active role in environmental issues including smoking, water and air pollution, radiation (e.g. Rocky Flats), and disaster planning.

You have had an equally forceful and authoritative voice in matters of emergency medical care and rural health care standards, in the monitoring of HMO/PPO/IPA insurance law changes, in the issue of foreign medical school graduates, in physician licensure requirements (e.g., CME), in the matters of certificate of need and workmen's compensation.

And that is only a partial list! Member dues dollars are returned many times over through the representation received which, otherwise, would cost each member many times his state medical society dues.

Your Public Health Council has, with the assistance of several component societies, hammered out and put in place an amphetamine prescription regulation, has developed a drug diversion training program, has established guidelines for physicians in attendance at sporting events, has dealt with such health issues as control of whooping cough, developed surveillance projects for urethritis and genital herpes, and the dispensing of non-prescription medicines in day-care centers. Public Health has been studying prescription drug abuse, alleged toxicity of mercury in silver amalgam dental fillings, and investigating the high incidence of injury resulting from so-called aerobics and exercise programs.

The CMS Council on Professional Relations and Medical Services has been closely involved with and worked on physician advertising issues, worked with the Bar Association Liaison, established a physician health and rehabilitation program. The Council's Jail Health Care Standards project, which is in its fourth year, is one of the most successful programs of its kind.

Your Council on Socio-Economics is currently monitoring and reporting to members on matters of the medically indigent, Medicaid, HMOs, PPOs and IPAs (the CMS staff being a prime source of consultation and advice concerning these groups to inquiries from throughout the United States). Socio-Ec is currently doing fee reviews for private health insurance carriers, reviewing physician contracting and certificate of need.

These councils, their committees and their programs all work to your individual benefit, allowing you to continue in medical practice without taking valuable time away from your patients.

Aside from all this... out of the mainstream of CMS activities, are

CMS can only be as effective as its members allow it to be.

ance Committee. One large lawsuit against you and you'll find your yearly dues in Colorado Medical Society will pale in comparison to what these two bodies can and will do for you and save you!

This year, CMS has organized and put into operation the Medical Staff Section which recognizes the needs and allows the input from your hospital medical staff at the CMS House of Delegates. We are not the first... but CMS is among the leaders in implementing this kind of representation in organized medicine.

Let's talk for a moment about other, more personalized successes of your organization: It took three years, but CMS now has one of the most successful professional liability insurance programs for its members. Soon, this Trust... and its attendant insurance company... will provide you a full line of personal insurance programs to save you money, provide the protection you require and further reduce or stabilize CMS dues. It's an organization controlled by physicians... *for* physicians!

CMS now has business overhead and disability insurance programs, and will soon have other programs in the hazard and casualty fields; quality programs that you can't obtain anywhere else. CMS will make every effort to keep the expense of these programs as low as possible.

Colorado Medical Society has an active and effective relationship with national organized medicine... working closely with and being represented in the AMA. CMS's membership in this federation has paid off handsomely for each of you this year... just in the defeat of the mandatory assignment legislation. CMS has scored political victories on both the state and national scene during the past three years through the Colorado Medical Political Action Committee (COMPAC). Through its association with AMPAC, COMPAC is a vital, alive organization playing a key role in shaping our congressional and legislative representation here and in Washington, D.C. COMPAC continues to grow... and it is not just because COMPAC exists... it's because leadership and staff of CMS perceive the need and work diligently to keep its physician members involved at all levels of government. *You can not do any of these things alone!*

CMS is involved in a project to give this organization the permanent home it needs. That permanent home will become a reality, and you... the CMS member... will finally have an equity in your organization which will help stabilize dues and cut operation costs for years to come! Certainly, there have been problems... problems with this project... but that is not to say that CMS has problems. Colorado Medical Society is a strong, healthy, viable organization of professionals. Any organization or business of our size has problems. It has been gratifying to see the recent participation by everyone working together to solve these problems.

This organization can only be as effective as its members allow it to be. CMS has an *expert* staff... widely diversified in fields where few physicians ever tread. Staff can do no more than your voluntary efforts will help them do... because

Preliminary Program
1984 CMS/CMSA Annual Meeting
September 20-22, 1984
Marriott Mark – Vail, Colorado

Wednesday, September 19

4:00 pm - 6:30 pm	Registration
6:30 pm	Welcome Reception Hosted by Marriott Mark

Thursday, September 20

7:00 am	Registration
7:00 am	Prayer Breakfast
8:00 am - 5:00 pm	CMSA Hospitality Area
8:00 am - Noon	House of Delegates (CFMC Corporate Meeting)
9:30 am - 4:30 pm	Country Store - CMSA
10:00 am - 2:00 pm	CMSA Tour and Lunch
Noon	Reference Committee Chairmen Luncheon
Noon	CMS Past President's Luncheon
1:30 pm	Reference Committee Hearings
2:30 pm - 4:00 pm	CMSA County Presidents/ President-elects
4:00 pm	Exhibits Open
4:30 pm - 6:30 pm	Exhibitors Reception in Exhibit Area
6:00 pm - 7:30 pm	CMSA Reception - Honoring AMAA President-elect, Mary Kay McPhee

Friday, September 21

7:00 am	Registration
8:00 am - 4:30 pm	Exhibits
8:00 am - 5:30 pm	CMSA Hospitality Area
9:30 am - 4:30 pm	Country Store - CMSA
8:30 am - 3:30 pm	Scientific Progam - "Changing the Face of Medical Practice"
8:30 am - 9:30 am	(Keynote) Futurism/Medical Economics
9:30 am - 10:30 am	Other Key Viewpoints (Panel) • Hospitals • Business and Industry • Medical Insurance Carriers • HMOs/PPOs/IPAs
10:30 am - 11:00 am	BREAK (exhibit area)
11:00 am - noon	Panel continues
11:45 am - 1:00 pm	COMPAC Luncheon
1:30 pm - 2:30 pm	To Be Announced
2:30 pm - 3:30 pm	Impact of the Future on Medical Practice Sponsored by CMSA
6:30 pm	Presidents' Reception
8:00 pm	Presidents' Dinner

Saturday, September 22

8:00 am - 3:00 pm	CMSA Hospitality Area
8:00 am	Registration
8:00 am - Noon	Exhibits
8:30 am	CMSA Open Board Meeting
8:30 am - 11:00 am	Scientific Program - Workshops (Three Concurrent Sessions) • Ethics Workshop • Recent Scientific Investigations of the Shroud of Turin (John Jackson, Ph.D., Vice-President, Shroud of Turin Research Project) • To Be Announced
9:00 am - 2:00 pm	Country Store - CMSA
10:00 am	CMSA General Membership Meeting (Installation of Officers)
Noon	CMSA Annual Luncheon
1:30 pm	House of Delegates
2:00 pm	CMSA Incoming Board of Directors Meeting

hey are *your* staff... they follow *your* directions.

CMS members asked for an *educational and research foundation* to continue efforts in behalf of the best in medical education. It took two years, but CMS *has* an E.R.F. which is already growing. It is healthy and meaningful, and will continue to grow. It is in place to help you, and the many like you to follow. E.R.F. gives us another voice in the destiny of medical practice. *You couldn't do it by yourself!*

Nothing worthwhile comes easily or without problems, but we've worked them out. Now, more than ever before, the persons entering medical practice need the strength, the fellowship and the single voice of the state and its component societies. The adage of the '70s of "doing your own thing" *does not* and *cannot* apply to the practice of medicine. If the young, or even the more mature, physician doesn't realize

Since 1871, CMS has been an integral part of medicine in Colorado.

the need for such an organization, then that physician just hasn't been in practice long enough, doesn't understand what his/her society is doing for him, or hasn't been touched yet by the changes occurring in the health care delivery system. The need for this organization will not be denied by a "freedom of choice" amendment to its bylaws; in fact, these are the times when this state society and its component organizations must work as a single unit to respond to the changes occurring in the health care system. These are the times which cry for a greater unity among our professional members!

Yes, I have learned! I have learned that there's an "unseen" Colorado Medical Society. It is an organization of elected and appointed leadership with an outstanding paid staff... working 24 hours a day, seven days a week on your behalf... representing each of you. I have learned that it takes much more than paying my dues on a yearly basis to my component and state society to ever appreciate all the resources this organization represents. I have learned that the organization represents a body of decision-makers... no decision is left to one individual. Decisions of the magnitude of this organization *do* move from component to committee, to council, to Board of Directors, to House of Delegates... and then to staff to carry out the wishes of the CMS members.

When you ask about Colorado Medical Society successes, problems and solutions, they are almost too numerous to list. But the sum of all of them represents a highly successful, highly motivated organization of people who make up the finest professional body in existence.

Only by participation in this organization can we make CMS more effective. CMS *can* be more effective... I don't deny it. I can't do it alone! Neither can you! I have learned a lot in the past two years. One of the most important things is that my organization is working for me. It is also working for you!

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Continuing Medical Education

CALENDAR

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July, 1984

9-13 **20th Annual Internal Medicine Program** — YMCA of the Rockies, Estes Park, Colorado. Hours: 25 Category I AMA; 25 prescribed AAFP credit hours, and 25 Category 2-O AOA hours. Contact: Office of Postgraduate Medical Education. University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262 (303) 394-5241.

10-14 **Aspen Summer Ski Seminar** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 16 Category 1 AMA; 16 Category 1 AAD hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262 (303) 394-5241.

18-20 **Confusion: It's Not All In Your Head** — (Altered Mental States of the Elderly) — 2nd Annual Summer Geriatrics Conference - Sheraton Inn, Lakewood, Colorado. 28 contact hours AMA Category I. Fee: $150, or $60 per day. Contact: LeRoy King, Ph.D., Education Oirector, Beth Israel Education Center, 1601 Lowell Blvd., Oenver, CO 80204, (303) 825-2190, Ext. 266, 457 or 358.

24-27 **CACMLE Conference In Clinical Laboratory Practice** — Lake Oillon Holiday Inn, Frisco, Colorado. Courses are NCA accredited. Contact Colorado Association for Continuing Medical Laboratory Education, 1785 Quebec St., Denver, CO 80220, (303) 321-1734).

26-27 **Advanced Trauma Life Support** — Orr Major Hall, University of Kansas Medical Center, Kansas City, Kansas. Credits: 16 hours AMA Category 1; 15 hours AAFP; 15 hours AOA 2-D. Fee: $350. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th and Rainbow, Kansas City, Kansas 66103, (913) 588-6124.

30-3 **Dynamic Psychotherapy** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 18 hours AMA Category I, 18 APA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

August, 1984

2-5 **Third Annual Ku Summer Medical Symposium Medicine For The Practicing Physician** — The Broadmoor Hotel, Colorado Springs, Colorado. Credit: 12 hours AMA Category I; 12 hours AAFP; 12 hours AOA Category 2-D. Fee: $325. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103, (913) 588-4480.

4-5 **Pediatric Sports Medicine** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 9.5 hours AMA Category I, 9.5 prescribed hours AAFP; 9.5 hours Category 2-D AOA. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

6-9 **27th Annual Pediatric Program** — Given Institue of Pathobiology, Aspen, Colorado. Credit: 21 hours AMA Category I; 21 prescribed hours AAFP; 21 hours Category 2-D AOA. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

8-9 **High On The Foot** — Marriott Mark Resort, Vail, Colorado. Credit: 13 hours AMA Category I; 13 prescribed hours AAFP, 13 hours Category 2-O AOA. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

9-11 **38th Annual Rocky Mountain Cancer Conference For Medical Professionals** — Fairmont Hotel, Denver, Colorado. Seminar will be a lung symposium in honor of Geno Saccomano, MO. Co-sponsors of the program are the American College of Chest Physicians and the American Lung Association. Registration deadline: August 1. Contact: Chris Heminway, RN, American Cancer Society, 2255 South Oneida, Denver, CO 80224, (303) 758-2030.

9-12 **10th Annual Primary Care Orthopedics** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 21 hours Category I AMA, 14 prescribed AAFP hours, 14 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

12-14 **Primay Care Of The Back** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 14 hours Category I AMA, 14 prescribed AAFP hours, 14 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

14-18 **Kidney Disease, Hypertension and Disorders of Fluids and Electrolytes** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 19 hours Category I AMA; 19 prescribed hours AAFP; 19 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

20-22 **VIII International Congress on Hyperbaric Medicine** — Hyatt Regency Hotel, Long Beach, California. Conference will include original papers, exhibits, poster presentations and plenary sessions. A call for abstracts (approximately 200 words) should be submitted to: The Secretariat, VIII International Congress on Hyperbaric Medicine, % Baromedical Oept., P.O. Box 1428, Long Beach, CA 90801-1428, (213) 595-3613.

22 **Mammography** — Julesburg, Colorado. Speaker: Edward E. Callaghan, MD. Credit: AMA Category I and 2 prescribed hours AAFP. Contact: Martin J. Rubinowitz, MD, The Denver Clinic, 801 E. Colfax Ave., Denver, CO 80203, (303) 831-7171.

27-31 **University of Colorado Internal Medicine Board Review Course** — Denison Auditorium, University of Colorado School of Medicine, Denver, Colorado. Credit: 44 Category I AMA. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

30-2 **32nd Annual James J. Waring Chest Conference** — Longs Peak Inn, Estes Park, Colorado. Contact: Shirley Lindquist, American Lung Association of Colorado, P.O. Box 921, Loveland, CO 80539, (303) 667-5198.

new members

Arapahoe Medical Society

William Dahlberg, MD
9597 E. Orchard Drive
Englewood, CO 80111

Richard C. Heckmann, MD
5290 E. Yale Circle, #200
Denver, CO 80222

Virginia M. Moore, MD
7750 S. Broadway
Littleton, CO 80122

Fredric A. Schroeder, MD
2090 S. Downing St.
Denver, CO 80210

Boulder Medical Society

Joe M. Swartz, MD
909 Alpine
Boulder, CO 80302

Clear Creek Valley Medical Society

John C. Breckenridge, MD
4045 Wadsworth Blvd., #304
Wheat Ridge, CO 80033

Jennifer H. Caskey, M D
6401 W. Colfax Ave.
Lakewood, CO 80114

Dennis E. Doherty, MD
1050 S. Monaco Parkway, Unit 47
Denver, CO 80224

Denver Medical Society

Christopher K. Chung, MD
5180 S. Estes St.
Denver, CO 80122

Ellen R. Cooper, MD
885 ELm St.
Denver, CO 80220

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1127 Detroit St.
Denver, CO 80206

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2519 E. Kentucky Ave.
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Stephen D. Jackson, MD
2005 Franklin St., #440
Denver, CO 80205

Edgar L. Makowski, MD
4200 E. 9th Ave.
Denver, CO 80262

Frank D. Manart, MD
2005 Franklin St., #700
Denver, CO 80205

Wayne Sinclair, MD
12885 E. Nevada Ave.
Aurora, CO 80012

Russell C. Schultz, MD
10583 W. Turtle Mountain
Littleton, CO 80127

William F. Styler, MD
7904 S. Olive Ct.
Englewood, CO 80112

Ross M. Wilkins, MD
1830 Williams St.
Denver, CO 80218

El Paso County Medical Society

Ruedi P. Gingrass, MD
1715 N. Weber, #300
Colorado Springs, CO 80907

Gayl M. Godsell-Stytz, MD
7684 Safari
Colorado Springs, CO 80918

Mary Shakzadi, MD
7927 Horizon Dr.
Colorado Springs, CO 80918

La Plata County Medical Society

Judith A. Harrison, MD
2277 W. 2nd Ave.
Durango, CO 81301

obituaries

Albert McCoun Tipple, MD, of the Pueblo Medical Society died April 18 in a local hospital. Dr. Tipple, a retired otolaryngologist, practiced in the community for almost 50 years.

He was born in Pueblo February 20, 1906 and was a lifetime resident. Dr. Tipple graduated from the University of Colorado Medical School. During World War II, he served in the South Pacific in the U.S. Army..

Dr. Tipple and his wife, Decima, were married September 16, 1949 in Juarez, Mexico.

He was a past president of the Pueblo Medical Society and the Pathological Society. Memberships included the Ascension Episcopal Church; Sigma Alpha Epsilon; Pueblo Lodge 17, Southern Colorado Consistory; and Al Kaly Temple, AAONMS.

Dr. Tipple is survived by his wife; daughters, Shelley Tipple, Pueblo; Michele Tipple, Boulder; and Jennifer Anjier of Baton Rouge, Louisiana; and two grandchildren.

University of Colorado Student Medical Society

Alexander C. Philpott
4675 Lafayette St.
Englewood, CO 80110

Dianne E. Thorpe
1825 Zinnia Ct.
Golden, CO 80401

Pueblo County Medical Society

Mark S. Flora, MD
1600 W. 24th St.
Pueblo, CO 81004

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PROFESSIONAL OPPORTUNITIES

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INTERNAL MEDICINE PRACTICE FOR SALE — Tremendous opportunity; south Denver. 1983 net more than $100,000; includes all equipment. Terms negotiable. Call (303) 691-2550 evenings. 584-1-2b.

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POSITION AVAILABLE — The position of Director of Medical Affairs at Porter Memorial Hospital and Swedish Medical Center will be open in late 1984. For information please call Gary VanderArk, MD, 761-2002. 684-I-1b.

INTERNIST OR FP to join solo MD in busy office and hospital practice. Must be well-trained and of highest moral caliber. 2 months vacation. Immediate Partnership. No investment. Denver, CO (303) 293-2007. 684-1-3b.

FP: Large Community Health Center seeking dedicated, BE/BC FP applicants to join an established practice focusing on continuous Pt. care, education, and outreach. Good hospital and residency affiliation. Excellent benefits and competitive salary. Contact: David Simmons, MD, (303) 353-9403, Ext. I9. 684-1-3b.

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COLORADO LICENSED MDS needed to perform insurance medical exams. Minimal travel involved. Hours flexible depending upon availability, MDs needed in Denver, Colorado Springs and in other cities in Colo. (303) 751-9903 or write Apps, 8000 E. Girard, Denver, CO 80231. 684-1-Ib.

MIDWESTERN FAMILY PRACTICE: Aggressive regional health services group seeks physicians interested in contemporary continuing care family medicine. Our midwest opportunities offer a wide variety of practice settings; most in county seat communities with hospitals. Community profiles available. Guaranteed salary can be arranged. Contact Duane Etter at (515) 282-0294 or by letter at 600 5th Ave. Plaza, Suite D, Des Moines, IA 50309. 684-1-1b.

INTERNAL MEDICINE practice opportunity in Ft. Lupton, Colo., a progressive rural community of 5000 population 25 miles from Denver. New 58-bed Brighton Hospital 6 miles away. Contact: Harold Buck (303) 659-1531. 684-1-3b.

FAMILY PRACTITIONER: Established Eastern Colo. practice needs a board certified or eligible FP to join MD and PA. Well-staffed and fully equipped clinic, modern 21 bed hospital. Prosperous farming and ranching community qualifies as BCHS shortage area. Excellent financial situation in extremely stimulating setting, great potential for growth. Located only 90 minutes from Denver and mountains. Contact: Thomas Jeffers, MD, 1612 6th Street, Limon, CO 80828, (303) 775-2367. 684-1-Ib.

IMMEDIATE ADMINISTRATIVE and full/part time opportunities available for Board certified/eligible family practitioners and internists to join longstanding medical service corporation serving Aurora and Dillon, Colorado. For further information call (collect) Barbara Wilczynski, Medical Emergency Service Associates, (312 459-7304. 684-1-3b.

GENERAL INTERNIST BE/BC preferably with existing practice to associate with 3 internists in midtown area. Call W. A. Foutz, MD, (303) 399-0313. 684-1-3b.

PEDIATRICIAN AND OB-GYNECOLOGIST wanted for association with the Fort Morgan Medical Group. Call Ham Jackson, MD, 867-5681. 584-1-3b.

OB-GYN NURSE PRACTITIONER wanted part time for busy full service practice. Excellent references essential. (303) 789-6660, Suite 160 Swedish Medical Plaza, 601 E. Hampden Ave., Englewood, Colorado 80110. 584-1-3b.

COLORADO, GOLDEN: Physician needed for an established, growing minor emergency clinic practicing episodic care, industrial and sports medicine. Golden is a university town of 15,000 located in the Rocky Mountain foothills, 20 miles west of Denver. Excellent professional and recreational opportunities. B/C or B/E in EM, IM or FP required. Salary and benefits competitive. Send C.V. to: John R. McInerney, MD, F.A.C.E.P., 1224 Arapahoe St., Golden, CO 80401; (303) 277-0780. 584-1-3b.

TWO FAMILY DOCTORS needed to join active family practice in Aurora, Colorado. Guaranteed income. Send resumes to: Marvin N. Cameron, MD, 3451 S. Chambers Rd., Aurora, Colorado 80014. Or call (303) 693-7908. 484-1-4b.

COLORADO, DENVER: Emergency/urgent care center with primarily E.M. practice is seeking two qualified physicians. Must have a CLS and also E.R. experience. E.M. F.P. residency desirable. Salary and benefits competitive. Contact Gregory E. Leach, MD, Medical Director, Arvada Emergency Center, 9950 W. 80th Ave., Arvada, CO 80003. (303) 425-0806. 484-1-3b.

FAMILY PRACTICE OPPORTUNITY: Colorado's Western Slope. Grand Junction solo family practice doctor retiring July, 1984. Will lease or sell property with office and apartment directly across from 250 bed general hospital and medical center. Area offers great recreational activities – three golf courses plus fishing, hunting and skiing on Grand Mesa – 45 minutes away. Metropolitan area of 51,000 – very friendly community in which to raise a family – four year state college. Send all inquiries to Family Practice Opportunity, PO Box 2026, Grand Junction, Colorado 81502. 484-1-3b.

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ablished practice in one of Colorado's ost desirable living areas. Gross 130,000, flexible terms. Moving out of ate. Your opportunity to locate in prime unting, skiing and recreational area. hone (303) 247-0647 (office) or (303) 59-3742 (home) after 5 pm. 484-1-3b.

RIMARY CARE PHYSICIANS needed o staff freestanding urgent care facility in Colorado Springs area. Total compensation pprox. $45,000/year for 42 hrs./week. ddress inquiries to Richard Wall, MD, ikes Peak Emergency Specialists, 2310 No. Tejon St., Suite 101 or call (303) 36-3703. 484-1-3b.

WANTED F.P., (man or woman) for SW Colorado, 3-person group. 120 days vacation. Excellent skiing, hunting and fishing. 303) 882-7221 days, 882-7328 nights. 284-1-5b.

SITUATIONS WANTED

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BOARD-CERTIFIED EXPERIENCED young family physician desirous to join one or more physicians in Denver/Boulder/Colorado Springs area. Available immediately. Call Mike Willig, MD, 669-2849 days, 221-0794 eves. 684-1-2b.

PHYSICIAN ASSISTANT. AMA approved. Grad. Wichita State University, KS P.A. Program. Desires position with doctor. Available August, 1984. Quality references. Douglas Starnes, (303) 848-2517 or 5448, 618 S. Yuma St., Yuma, CO 80759. 684-1-2b.

BOARD-CERTIFIED GENERAL SURGEON, 36 yrs. F.A.C.S. with interest in surgical oncology, non-cardiac thoracic surgery, general surgery and endoscopy. Available immediately. (405) 225-0825. 584-1-3b.

PHYSICIAN ASSISTANT: '82 graduate. I am presently with a burn/trauma unit and emergency department air transport system. I also have experince in family practice and teaching/administration at a university level. I am seeking a family practice and/or emergency medicine position in rural or urban Colorado. Available immediately. For CV: Jeff Birkinshaw, 2060 Hollywood, Salt Lake City, UT 84108 (801) 487-6328. 484-1-2b.

ENERGETIC YOUNG GENERAL INTERNIST, ABIM. Denver native, wishes to relocate practice to Colo. Group or partnership. Well-trained. Steve Gorshow, MD, 600 N. McClurg Ct., #1611, Chicago, IL 60611. (312)944-7123.

PROPERTIES

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COPPER MOUNTAIN, Colorado — Spacious 3 bdm/3¼ bath, 1600 sq. ft. Spectacular views of the mountain, furnished, $249,000. Call or write Carbonate Real Estate, P.O. Box 3216, Copper Mtn., CO 80443, (303) 968-6854; ask for Pat. 684-1-1b.

CONVENIENT TO PORTER'S. Up to 1720 sq. ft. available in established medical building at 2090 S. Downing. Easy access from I-25, Colorado, Broadway and Evans. Radiology and lab on premises. The South Downing Professional Building has everything except high price. Call Walt for appointment, 333-8600. 684-1-4b.

NEW PROFESSIONAL BUILDING NOW LEASING. Gorgeous view and prime location, affluent growing community. Services already available — dermatologist, pedodontist, orthodontist, oral surgeon and family dentists. For information contact Joan Wilson of Wilson Agency/Metro Brokers 593-8888, Colorado Springs. Option to buy is available. 584-1-2b.

LUXURY CORPORATE RETREAT. Breckenridge, Colorado. In town. Six bedrooms, two complete kitchens, two dens. Sleeps up to 20. Cable TV, 7 foot indoor hot tub, large sun deck. Call 691-0400. 584-1-3b.

COPPER MOUNTAIN, COLORADO — One bedroom/loft, 1¼ bath condominium, newly-carpeted and furnished. Western exposure, on the golf course, overlooking stream, 100 yards from "B" lift, priced at $142,900. Call or write Carbonate Real Estate, P.O. Box 3216, Copper Mountain, CO 80443. (303) 968-6854. Ask for Patrick. 684-1-1b.

TEST YOURSELF

Q

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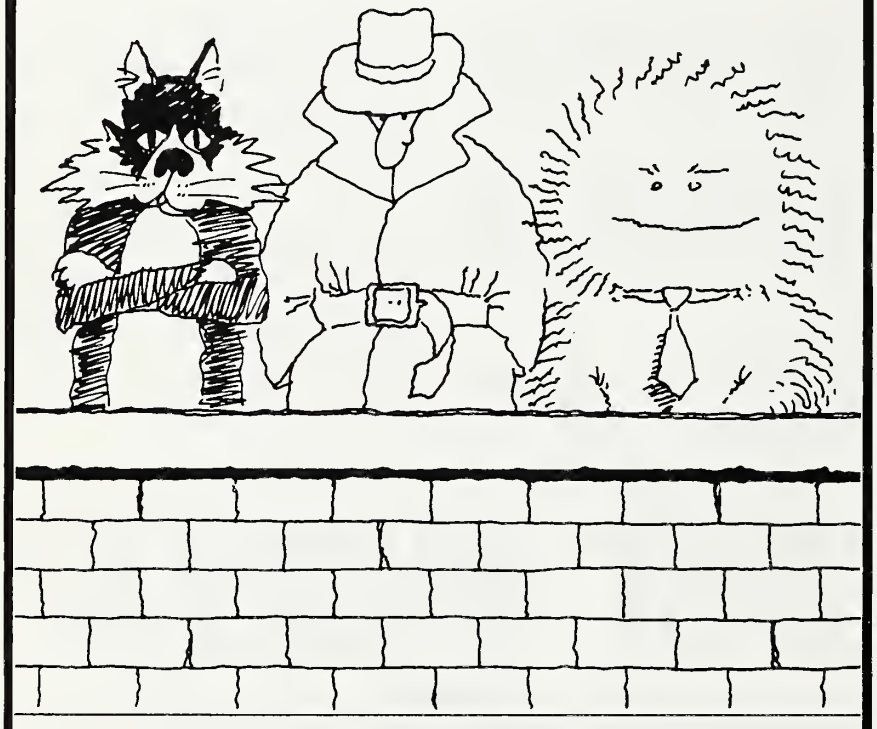
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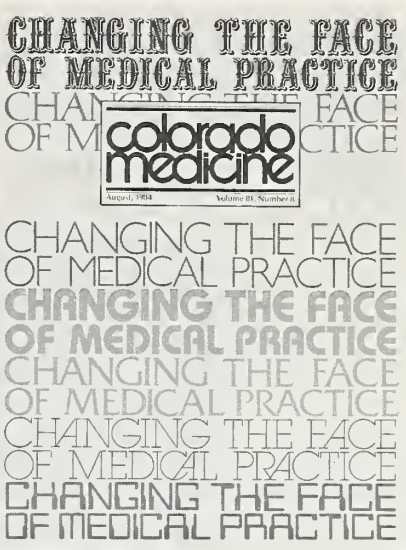
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This Month's Cover:

"Changing The Face Of Medical Practice" is the theme of the 1984 CMS Annual Meeting. The 114th meeting of the Colorado Medical Society will take place September 20–22 in Vail.

This year's scientific program will focus on the economic issues facing physicians today. According to program chairman Arnold Greensher, MD, the program will be "raw, hard reality and facts." His article, "Medicine in the '80s—Survival in an Age of Change," describes the issues and problems to be discussed in the program. It begins on p. 202.

The President's Letter (p. 183) and Auxiliary Report (p. 184) include information about other events which will take place in Vail. The preliminary program schedule, p. 204, gives times and dates for these events.

It promises to be a great meeting!

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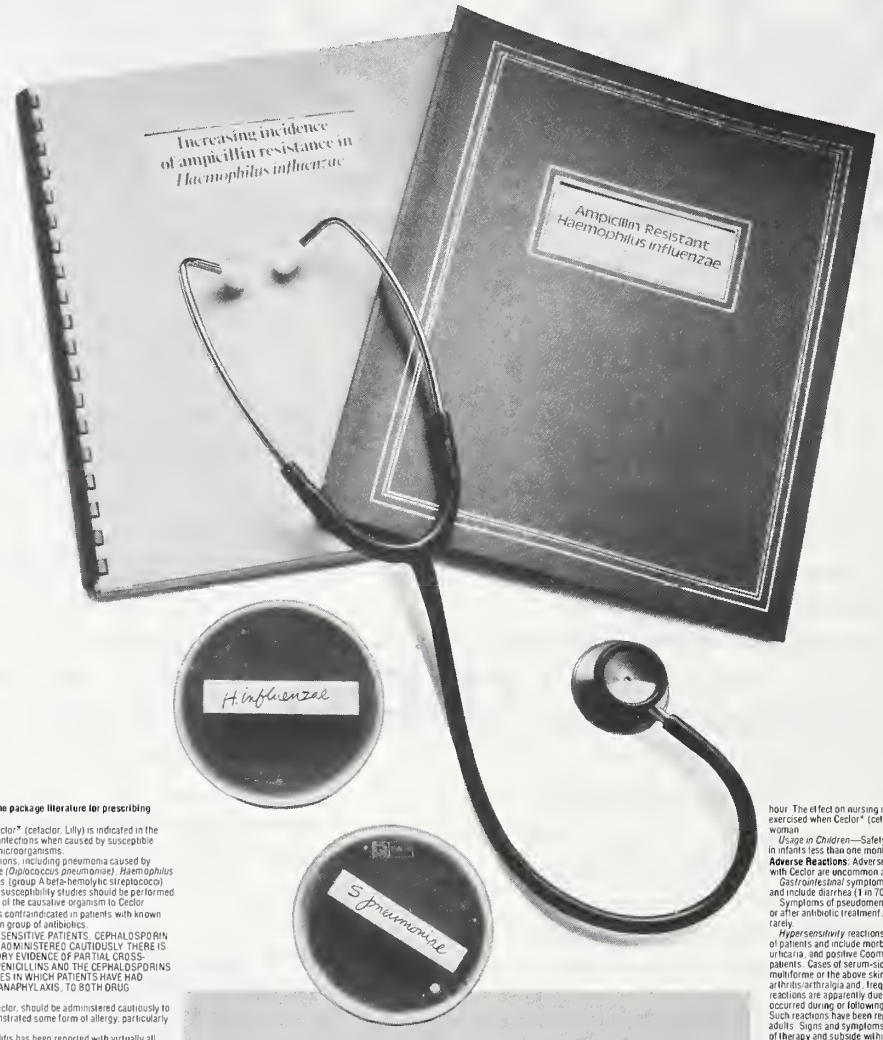
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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should be ruled out.

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor* (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.* †

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

†Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

Changing the Face of Medical Practice

Issues and changes that the medical profession is and will experience in the health care delivery system will be the central theme for the annual meeting of the Colorado Medical Society, to be held in Vail September 20-22, 1984. As the title of the scientific program, "Changing the Face of Medical Practice," implies, the lectures and workshops are designed to acquaint you with these changes, present their impact and influence on your medical practice, as well as the health care being received by the people of Colorado and finally to stimulate positive action as you meet these problems in your daily patient care.

I look forward to seeing you in Vail!

The details of the scientific program are given elsewhere in this magazine but the titles are: The Evolving Competitive Market Place; Consumers' Views of Medical Care and Medical Cost; and Role of the Medical Profession in the Emerging Integrated Health Care Organization, which will take place on Friday; DRGs and the Hospital; Ethical Implications of Rationing and Cost Containment; and Recent Scientific Investigations of the Shroud of Turin, which will take place on Saturday.

The meeting promises to be a relaxing change of pace as well as a scientific and work session. It will open with a bicycle trip to Vail from Denver led by my son Bruce, with points of entry for all levels of bikers, from competitors to neighborhood riders. The aspens should be showing their golden hues and hiking, tennis and golf will be available for those leisure moments.

I would recommend that you mark your schedule now to attend the annual meeting in Vail. Fond memories are still being recalled of our last year's meeting in Tamarron and this meeting will be even better. Plan for Vail. I look forward to seeing you there!

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auxiliary report



Bunkie Inkret, President
Colorado Medical Society Auxiliary

Once again a mountain resort area looms on the horizon for the Colorado Medical Society members and auxilians planning to attend the annual meeting. Last year we met in Durango at Tamarron. This year it will be Vail, which promises an exciting time that will be remembered long after the final gavel ends the official business.

Indeed, if there is a resort area in Colorado that enjoys and entertains visitors it is Vail. Enclosed in the auxiliary registration packet will be a book of restaurants, shops, tours and recreation available for mid-September.

Mary Kay McPhee, a resident of Kansas City, Missouri, and currently the American Medical Association Auxiliary President-elect, will be the national visitor and special guest. We invite you to come to meet her at the auxiliary cocktail reception on Thursday evening. This reception will be held in the Muftic condominium at the Villa Cortina.

Read the accompanying short article by CMSA Program Chairman Sharon Ferlic about the speaker, Dr. Leland Kaiser, whom we are sponsoring for the scientific session. You will not want to miss hearing him, so remember to plan your recreation around his address.

I hope you will also plan to attend the Presidents' Dinner, which will be preceded by cocktails and followed by dancing to the "Big Band" sound. It will be a great time to relax and enjoy the friends that we see only once a year at this meeting.

The auxiliary is again providing a hospitality area and the Country Store, to raise money for AMA-ERF. They will be located in a convenient area near the main lobby; we hope they will provide a meeting place or recreation area where you can sit and relax.

The business sessions of the auxiliary will be on Saturday and do begin at an early hour. This day and meeting are highlighted by the installation of the new officers; you are invited to attend this ceremony. We hope you will take this opportunity to share in the installation of the new president, Mary Hanson.

We want to share with you the vitality, spirit and tradition that characterizes our auxiliary, which is especially present during the time of an installation.

On behalf of the members of the Colorado Medical Society Auxiliary, it is our sincere hope that having combined annual scientific sessions, business meetings and social events will help to ensure the continuation of the accomplishments of our organizations.

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Leland R. Kaiser, Ph.D.

What will be the future of medicine? A topic that may directly affect our lives will be presented by Dr. Leland Kaiser at the Colorado Medical Society Auxiliary Scientific Session in Vail, Friday, September 21 from 2:30-3:30 pm. Dr. Kaiser is a nationally-known health futurist who is president of Kaiser and Associates, as well as associate professor of health administration in the Graduate School of Business Administration at the University of Colorado.

He is an acknowledged authority in health futurism, hospital governance, medical staff relationships, innovation, management practice, nursing administration and volunteer administration.

Dr. Kaiser has previous professional experience as a hospital administrator, research and development director, health planner and academician. He has served as a hospital trustee and has practiced as a psychologist.

His academic qualifications include a master's degree in clinical psychology, a master's degree in medical care administration and a Ph.D. in social psychology and higher education from the University of Denver. Dr. Kaiser has received numerous professional honors and is author of many publications.

copic report



K. Mason Howard, MD, Chairman
COPIC Trust

Doctor Companies and the Reinsurance Market

Editor's Note: This month *Colorado Medicine* inaugurates a new column for our readers. Authored by various COPIC directors and professional staff, it will include news of the medical liability insurance field, informative discussions of malpractice issues, and professional liability trends and updates, both in Colorado and nationwide. We invite questions, comments and suggestions.

Since the "malpractice crisis" of 1974-75, more than 30 physician-owned and controlled professional liability insurance companies have been formed by state and large component medical societies throughout the United States. Those companies now write one-half of all the physician professional liability policies in this country, insuring 120,000 physicians with an annual premium volume of $800 million. COPIC Trust, awaiting licensure of its subsidiary COPIC Insurance Company, is the newest doctor company, soon to be followed by the Iowa State Medical Association Company.

The doctor companies have formed a national association, Physician Insurers Association of America (PIAA), as a vehicle for educational and communication activities among the members. PIAA activities are carried out through committees during the year, culminating in the annual meeting, which recently took place for 1984. While the liability problems of Florida, California and New York do not translate directly to Colorado, trends seem to begin in those densely-populated areas and eventually spread to us.

The message at PIAA from the reinsurance market, those excess carriers with all the exposure in megabucks liability awards, came through loudly and clearly. That is, while the "crisis" of the 1970s was a lack of reinsurance availability, the reinsurance will be available but the price is going up now. In addition, the reinsurers are asserting a stronger and more active role in operations of the companies they reinsure.

COPIC and its insureds are truly blessed by the strong and substantial backing afforded us through our reinsurance arrangements with North American Reinsurance. We have had available to us from the outset the abundant expertise of this reinsurance giant. We continue to cultivate that relationship for the strength it lends to COPIC's insurance program and the policy/management enhancements which develop from North American Re.'s advice and assistance.

COPIC Trust will soon be the newest doctor company in the country.

A very good standard for COPIC insureds to watch over time is the company's relationship to its reinsurer. So long as we sustain the current healthy relationship and retain the backing of the reinsurer's billion-dollar-plus capability, the strength and stability of your medical society's liability insurance program are assured!

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Medical Assistants To Host Seminar

The Colorado Society of Medical Assistants will host a seminar titled "Rhythms of Life" at Memorial Hospital in Colorado Springs on Saturday, September 13, 1984. The seminar will focus on the case of a heart attack patient, from the time of his attack through recovery and the patient's return to normal life. Registration deadline is September 1. Fees are $25 to members of CSAA, $30 to students and $35 to non-members. Lunch is included. For information contact Linda Murrah in Colorado Springs, 632-6676 or 574-9484 or Marsha Broste in Denver, 839-5091.

Free Assistance Offered to MS Victims

The Multiple Sclerosis Society of Colorado is offering a free peer counseling program to MS victims. This program is aimed at helping people who have MS overcome fear and depression because of their condition, to find additional health care, and cope with stresses within the family.

Each peer counselor is matched with a patient by sex, age and family structure. For further information, call the MS Society at 832-3728.

Dean Appointed for University of Colorado School of Medicine

The University of Colorado Board of Regents recently approved the appointment of Joseph W. St. Geme, Jr., MD as dean of the school of medicine and professor of pediatrics. He will assume the post January 1, 1985.

Dr. St. Geme, 53, is nationally-known as an academic administrator and medical educator. Currently he is professor and executive chairman of pediatrics at the University of California School of Medicine.

He received his bachelor's and medical degrees from Stanford University. His research centers on infectious diseases.

During his career, Dr. St. Geme has received numerous awards and honors, including the Ross Award for Pediatric Education from the Western Society for Pediatric Research in 1977; Outstanding Faculty Teacher Award, Pediatric Housestaff, Harbor-UCLA Medical Center, 1978-79 and a Project Head Start Service Award from the U.S. Department of Health, Education and Welfare in 1978.



Dr. St. Geme is active in many national professional organizations and committees. He was president of the Association of Medical School Pediatric Department Chairmen from 1981 to 1983. He is a diplomate of the American Board of Pediatrics and served as the board's president in 1983. He also served on the Residency Review Committee for Pediatrics from 1976 to 1982.

He has held numerous visiting professorships, including one in the CU School of Medicine in September, 1983.

He is author or co-author of more than 200 publications and has served as editor-in-chief of *Child Care*, a publication of Hoffman-LaRoche, Inc. He was a member of the editorial board of *Clinical Pediatrics* in 1979 and he is a reviewer for a number of professional publications, including the *New England Journal of Medicine, Journal of Pediatrics* and the *American Journal of Diseases of Children.*

Denver-Vail Bike Ride to Precede Annual Meeting

CMS physicians and families are invited to take part in a bicycle ride from Denver to Vail on Wednesday, September 19, the day preceding the annual meeting. The ride will begin at 6 am at the parking lot north of the freeway at Red Rocks exit off I-70. Arrival point will be the Marriott Mark in Vail. Competitive riders may want to make the whole trek; less experienced bikers may join or leave the ride when they prefer (a van will be accompanying the ride to pick up bikers, or help with needed bike repairs).

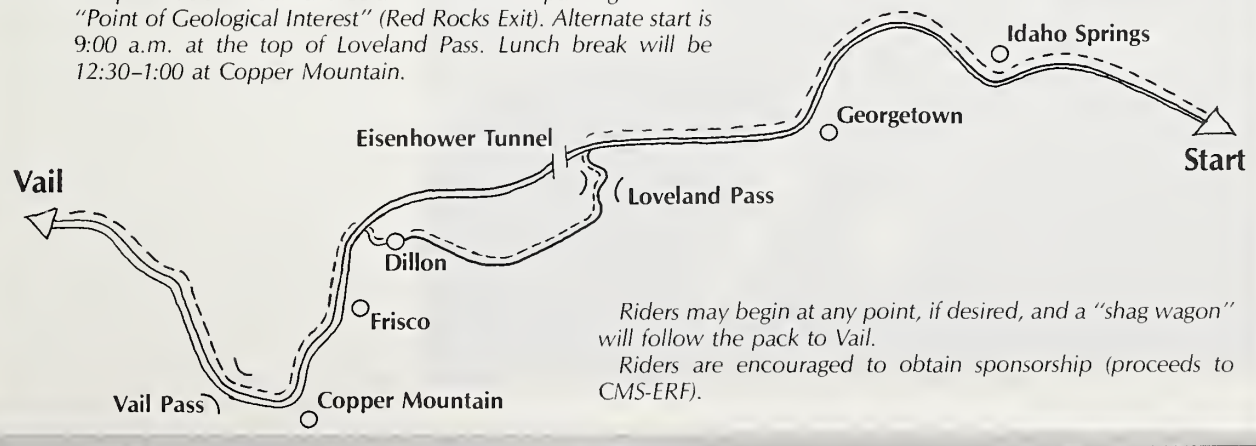
The ride is free, although there will be a stop for lunch. Bruce Whitesel, son of CMS President Dr. John Whitesel, will lead the ride. For information, call the CMS office at 321-8590.

Correction

An interview with Dr. Harvey Phelps in the June issue of *Colorado Medicine* stated that Dr. Phelps, Dr. David Bates and Dr. F. William Burrows initiated the SEARCH Program at the University of Colorado Health Sciences Center. In fact, it was the Family Medicine Commission that was the "brainchild" of Drs. Phelps, Bates and Barrows. The SEARCH Program was the accomplishment of Dr. Phelps and CU Regent Fred Betts.

Also, the name of Dr. Phelps' daughter, referred to in the article was Frances, not Nancy.

Expert riders will start at 5:00 a.m. at the north parking lot of the "Point of Geological Interest" (Red Rocks Exit). Alternate start is 9:00 a.m. at the top of Loveland Pass. Lunch break will be 12:30–1:00 at Copper Mountain.



Riders may begin at any point, if desired, and a "shag wagon" will follow the pack to Vail.

Riders are encouraged to obtain sponsorship (proceeds to CMS-ERF).

Should Doctors Learn To Say "No"?

Editor's Note: The following article is excerpted from the inaugural address of Joseph F. Boyle, MD, President of the American Medical Association, given in June at the AMA Annual Meeting.

In a ten-year period of time, at least 1,210,000 people in the United States will have died. Over 1,150,000 will have their lives shortened. Millions more will have been denied useful, productive and more comfortable lives because medical care had been denied them.

The question is, "What happened when American doctors learned to say 'no' to their patients?"

For over 2,000 years, since the time of Hamurabi, doctors of medicine have dedicated themselves to a code of ethics, and although changing times and mores have produced a different set of words and phrases, the underlying bent of our commitment has been to help the sick, to do no harm, to educate the novice and to share medical knowledge with fellow physicians. The code of our medical bond is well-summed up by two statements: The World Medical Association in 1948 said, "The health and welfare of patients shall be the first consideration, not allowing economics, politics, race or religion, or any other circumstance to take preference." A statement of the American Medical Association's Judicial Council says that while physicians should be conscious of cost, and not provide or prescribe unnecessary services, social policy expects that concern for the care of the patient will be the physician's first consideration."



Joseph F. Boyle, MD

Back to the question, the one about what happened when American doctors learned to say no. The answer I gave you is not a fanciful one. It is culled from data contained in a report by Henry Aaron and William Schwartz writing for the Brookings Institution in a book entitled, "The Painful Prescription." The report is a very thorough, careful and objective evaluation of the system of medical care in the United Kingdom as compared to that in the United States. Their data indicate quite clearly that were the standards for treatment now utilized in the United Kingdom applied to the people in the United States, there would be no fewer than 37,000 excess deaths a year from renal disease, 48,000 from cancer, 40,000 from coronary disease, 138,000 people would be denied the extension of a useful, productive and capable life. And that is just some of it.

Of critical importance to this country's physicians is the report's assessment of the attitudes of the United Kingdom's physicians. Doctors there gradually refine standards of care so that they can escape the constant recognition that financial limits compel them to do less than their best. They persuade themselves that patients lose nothing of medical significance when budget limitations force the provision of alternate forms of care, forms less than optimal. For the renal patient who dies, the victim of angina, in pain, the person with the misdiagnosed head injuries, alternate treatments, albeit good for the budget, are not good for them. For the physician who prescribes the alternate treatment under the pressure of resource limits, those pressures allow the doctor to avoid the painful realization that he or she is doing less than

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the best for patients.

One consultant noted "The physician has to look at the arguments for not treating a patient in order for the doctor to live with himself and to sleep well at night." In the United States, after 20 years of searching for means to assure access and availability of high-quality medical care and hospital services to every person in the country, after eight years of agonizing over how we can reduce the escalation in the cost of care and promote economy and efficiency in the delivery of health care services, we have progressed to the question of how best to limit access, decrease demand and ration care. If you are pondering the appending of "we have progressed" to the question of reducing care, we can go on to the next query.

For the question before us now is how do we as a profession respond to the challenge of achieving true progress instead of the retrenchment just described. To me, it does not involve learning to say no to our patients, but instead requires a rededication to our professional ethics.

Remember we are the profession that helps the sick, does no harm, educates the novice and shares medical knowledge with fellow physicians. We are the people who believe that concerns for the care of the patient will be the physician's first consideration. Contrast these ethics with the advice that we now receive from marketing experts, entrepreneurs seeking membership in PPOs, economists, and, unfortunately, an increasing number of doctors of medicine.

Our professional ethic says that we are a collegial brotherhood and sisterhood in which our interests are mutually intertwined. A business ethic says "get your share, drive the other fellow to the wall."

Roger Evans in a special communication published in *JAMA* in April, 1983 entitled, "Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions," made it very clear that there is an inherent conflict between the rationing of medical care and resource allocation and the Hippocratic Oath. He said that if the individual responsible for the allocation of resources is the individual physician, then that physician must, perforce, give up responsibility for the individual person. Further, Dr. Evans points out that recent reports indicate that competition can have a negative impact on the quality of care patients receive. He also noted that when the public is exposed to decisions contrary to the interests of the person involved, decisions based on a mix of both medical and social criteria differentially valuing human life, the public will become increasingly irritated and resentful.

The review of the Health Policy Agenda showed that several principles clearly speak to the question of professional ethics. The report says primary responsibility for the establishment and implementation of professional standards should rest with the health care profession. It also states that institutions and health care practitioners should function according to codes of ethics that take into account traditions of the profession, moral codes of society and developments in science and medicine. Codes of ethics should be an addition to the requirements of the law and the dictates of personal

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conscience.

How do we resolve this principle with a possible dilemma to be faced by physicians when, because of DRG reimbursement or other resource limits, they are pressed to either discharge patients from the hospital prematurely or not admit some patients to a hospital at all? Clearly, in the adherence to principles of our profession, physicians should not accept a dictate that they will act other than in the best interest of the patients under their care.

But there are other pressures that make it increasingly difficult for us not to abandon the traditional ethics of our profession. Major pressures, the Federal Trade Commission and the Anti-Trust Division of the United States Department of Justice, have repeatedly asserted that they do not desire to interfere with a profession's need to establish standards for competence of professional conduct designed to protect the public from fraudulent practices, abuse of license, or hospital privileges and incompetent practices. But, in every instance, caveats are added which preclude medical societies from imposing sanctions on members who practice blatant quackery, habitually overcharge, practice beyond the scope of their clinical training experience or competence, or hold themselves out to provide diagnostic and treatment modalities that have no scientific basis and may even be patently dangerous and potentially lethal — and all of this in the name of competition.

Some physicians rail mightily at organized medicine's apparent impotence in the conflict. Legislators and the media often compound the issue by pursuing the theme that physicians think they are above the law and that medicine should be subject to the same rules as any business enterprise. Opportunistic trial attorneys seize upon carefully-drawn criteria designed as guidelines for appropriate care and use them against us in the courts during malpractice trials.

The net of all this fuss and fury has produced a loss of professional self-esteem, a decrease in our adherence to ethical standards, and a concomitant precipitous decline in public confidence. And this in a time when the public cries out that it needs to believe in institutions and needs confidence in those who minister to its needs. Is it any wonder that there is a loss of public confidence in its institutions?

I will suggest to you that we have an opportunity as a profession to regain the public's confidence if we are willing to accept the task of leading. Leading a restoration of simple morality in society, beginning with ourselves. We can accomplish this beginning with a rededication to a professional ethic.

- Why do we tolerate physicians in practice who, after contracting to have their medical education paid for at public expense, then default on their loans or their commitments to public service, or cheat on entrance exams or examinations for licensure?
- Should we not insist that medical schools include a mandatory course in ethics in the curriculum, when 70 percent of graduates tell us that their training has been less than adequate in helping them deal

(Continued on p. 208.)



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The Ole AMA Ain't What It Used To Be

Editor's Note: The following article, written by Whalen M. Strobhar, discusses how the American Medical Association put together a long-range plan to establish priorities for the association and better serve its members. The article is reprinted with permission from the April 1982 issue of* Association Management *magazine. Copyright 1982, by the American Society of Association Executives.

"If the American Medical Association did not already exist, would there be a need for it? If so, what would it look like?"

These are two tough questions — questions that some association executives would hesitate to pose, let alone answer, about their own organizations. But we at the American Medical Associaton, Chicago, did answer those questions. And the answers resulted in a transformation of our association.

AMA is not the same association that existed two years ago. It is new. And it is offering its members new programs and new services.

Membership hadn't kept pace

In the fall of 1980, the AMA Board of Trustees directed the staff to develop a plan for our house of delegates to use as it considered the association's future. The reason: The board believed a dues increase was necessary but worried that it could stymie membership growth.

Over the past several years, membership in AMA had increased. But the increase had not kept pace with the growth of the physician population in the country. And from our research, it was clear to us that there was a significant potential for growth at all levels of organized medicine.

Potential for growth, however, does not automatically translate into actual growth. There must be a need for the product — the services of the association to its members — and the product must be effectively marketed.

It took six months

Our staff, together with our board, spent six months working to make sure that the American Medical Association could, and would, meet the challenges of the future and serve the needs of its members and potential members. Here's how we did it:

We began by setting up two independent staff task forces: a senior vice presidents' task force composed of the four senior vice presidents of AMA and a membership strategy task force composed of staff members who work on membership relations and membership promotion.

The purpose of the senior vice presidents' task force was:

- To study the present and future environment of AMA and the role of the association.
- To review the existing activities of the association and the resources needed to fund those activities.
- To evaluate future activities and the resources that would be required.

Meetings methodology

I served as chairman of this group. Five meetings were held, all in the same month and all of them at the headquarters. Each of the meetings lasted for at least two hours. In advance of each meeting, the participants were given, in writing, the purpose of the meeting and the methodology to be used. The methodology consisted of five steps:

1. Review AMA's purpose, role and constituency.
2. Review the environment — the world in which AMA exists and will exist in the future.
3. Review programs in light of the information gleaned from steps one and two.
4. Review resources needed to fund those programs.
5. Develop program and resource recommendations.

At the first meeting, we reviewed this methodology and established a timetable to complete steps one through four. By the end of the fifth meeting, a timetable was established to complete step five.

We also established ground rules that the four senior vice presidents would observe:

1. The discussions and results of the meetings were to be confidential until the board took some type of action.

2. The senior vice presidents' task force would be staffed by the director of the office of planning. At each meeting, the members of the task force would brainstorm. As new ideas emerged, the director of planning, serving as secretary, would write them on a flip chart. As one page of a flip chart was completed, the secretary would remove it and tape it to the wall so that all ideas were visible during the discussion.

Following the meeting, the secretary would write a report on the essence of the discussion, share it with the task force members for the next meeting and, with the help of the chairman of the task force, prepare assignments to be completed for the next meeting. These assignments usually required the task force member to rank, evaluate and establish priorities for activities and needs.

3. The theme of these sessions would be the questions, "If the American Medical Association did not exist, would there be a need for it? If so, what would it look like?"

Following the five meetings, the progress of the senior vice presidents' task force was summarized and the summary given to the executive vice president. He reviewed the progress, suggested changes,

and directed the task force to proceed with step five — recommendations for programs and the resources needed to implement them.

In January 1981, another series of consecutive meetings was held to work out the fine points of what was becoming a plan for a new AMA.

Results pinpoint functions

When we presented our results to the executive vice president, we had answered the basic question. "Yes, there would be an AMA formed if one did not exist today." It would be designed to perform these functions:

- **Primary functions.** To represent members; to provide scientific, medical, socioeconomic and political information and other data pertinent to the medical profession; to establish, maintain and implement standards of conduct and performance; and to maintain and implement education standards — a primary responsibility shared with other organizations.

- **Secondary functions.** To provide membership benefits as well as membership training.

- **Necessary functions.** To maintain the organization's strength and to pay careful attention to administration and management.

Bringing this functional profile to life would require extensive organizational change, including a consolidation of programs and staff. Now, it was necessary to present the plans for a new AMA to the board of trustees for approval and eventually (present them) to the house of delegates.

Membership strategy task force

Meanwhile, the membership strategy task force was completing its work. This task force commissioned two outside consulting firms to conduct independent studies. One study surveyed the current attitudes of physicians toward a variety of dues bases, structures and categories, as well as attitudes toward current and future activities and functions of the AMA. The other study examined past behavior of physicians toward changes in dues.

It was the job of the membership strategy task force to help formulate the questionnaires and work with the outside consulting firms. Its work began in January 1981, and was completed by mid-March. Members of the task force included representatives from various AMA departments such as membership, economic research, marketing, public relations, communication, survey research and design, and planning.

The membership strategy task force's final report called for a revised dues structure for certain groups of members and an incremental dues increase over a three-year period consistent with the resource needs identified by the senior vice presidents' task force. The director of the office of planning merged the two task-force reports into one report, to be submitted to the board of trustees for review in April.

If the AMA did not exist, would there be a need for it?

The board made its changes and the final version of the report was prepared for presentation to the house of delegates in June 1981. The AMA house of delegates, consisting of elected representatives from constituent societies, is the ultimate governing body of the AMA.

Informing members

The day the board meeting adjourned, the AMA mailed copies of the board report with a cover letter of explanation to its nationwide mailing list of physicians and staff leaders. In addition, information kits that answered critical questions about the reorganization were mailed to state medical societies. Following the board meeting and prior to the house of delegates meeting, board members visited with leaders in as many states as possible to answer questions about the reorganization plan and to encourage its acceptance.

The house spent many hours discussing the report. Separate votes were taken on each of the board's recommendations and amended recommendations.

Not all of the board's recommendations were accepted by the house of delegates. However, the substance of the report was adopted, creating a new American Medical Association and a $35 annual dues increase in 1982. The house also accepted the principles of considering incremental dues increases in the next two years.

Guidelines that were followed:

In summary, here are the guidelines we followed:

1. Long-range planning is essentially the role of the chief staff officer in concert with the association's governing body. The dual participation is important for the validity as well as the acceptability of the results.

2. While communication is essential in an association's day-to-day operations, any long-range, sweeping changes are best kept confidential while in the planning stages. This keeps speculation from causing widespread panic among members and staff. The membership strategy task force did not know of the existence of the senior vice presidents' task force. This was kept a secret so the membership research would be free of bias and could either confirm or deny the findings of the senior staff. In this instance, the work of the senior vice president was verified by the independent research.

3. No plan is any good unless it is written. You must write down the purpose, timetable, methodology, process and results. This encourages clear thinking and ensures that everyone understands the accomplishments thus far and those tasks yet to be accomplished.

4. Independent research is essential to back up your findings. The results of the research lend validity to your conclusions and make the plan easier to sell.

5. Use previous research and studies as a basis for your long-range planning work. In this case, the senior vice presidents' task force drew upon the analyses and recommendations made by AMA's council on long-range planning and development.

6. When selling the ideas, it is best to use visuals as well as a written document. When staff presented



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its work to the board of trustees, a carefully-planned slide presentation, narrated by the executive vice president, provided a clear picture of the preliminary work and the results. In addition, when the board presented the plan to the house of delegates, a similar slide presentation accompanied the written report.

7. Timetables are important. If they are not set, written down, and communicated to everyone involved in the process, it is very easy to brainstorm endlessly about what can happen in the future.

8. Seclusion in the planning process is important. Although our task force met in the AMA building, we did meet in a conference room and no phone interruptions were allowed unless an emergency arose. You must devote your undivided attention to the task, and it should be over a concentrated period of time.

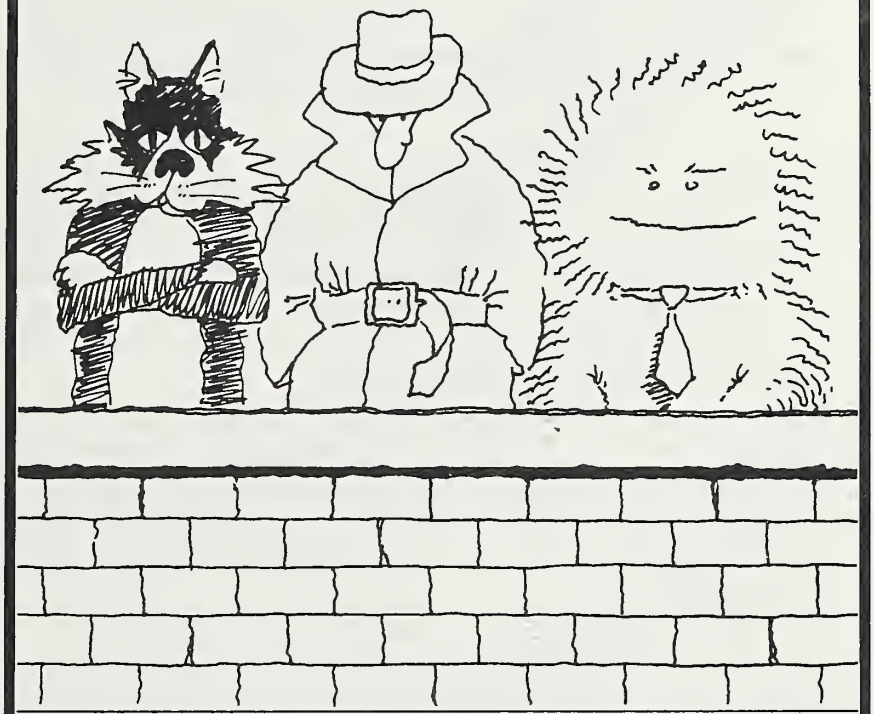
Something more than a plan

The long-range planning process accomplishes something more than an end result:

- It gives you the opportunity to deal with ideas and forces your attention away from the continual crises of the workday.
- It provides an opportunity for teamwork and a means of truly getting to know your peers and other staff members and their capacity for ideas and abstract thought.
- It allows you to focus on the future of your association and your own professional future.
- It commits your staff and board to a continuing review of activities, resources and functions.

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The Colorado Medical Society is an association of professionals which:

"Promotes the science and art of medicine, the betterment of public health, and the welfare of the medical profession and the patients it serves; and promotes the similar interests of its component and district medical societies."*

Through the variety of physician councils and committees, the Colorado Medical Society continually monitors public health concerns, proposed legislation relating to these and other health issues, recommends legislation which will work toward the betterment of public health and welfare of the medical profession and the patients it serves.

In providing a continuing professional lobbying staff, the Colorado Medical Society keeps its physician members abreast of all current issues before the Colorado General Assembly and the Congress of the United States.

With regular publications, CMS is also able to inform members of pending and current actions as taken by the CMS Board of Directors and the Society leadership.

Colorado Medical Society yearly publishes the Physician's Directory, the most complete physician referral guide for private practice physicians, health care and medical education institutions, legal and insurance professionals, federal, state and local government offices and agencies.

A continuing program of public health information is conducted by the Colorado Medical Society and the Colorado Medical Society Auxiliary, working closely with public, private and parochial schools for the most complete program of health education and health awareness among primary and secondary school students.

Colorado Medical Society provides its own members with a continuing medical education program, year-around, involving numerous areas of specialty practice and general medicine. Such continuing medical education classes, seminars and symposia are accredited, and are announced in the monthly CME Calendar published jointly by the Colorado Medical Society and the Colorado Foundation for Medical Care.

Colorado Medicine is the official journal of the Colorado Medical Society, and in its short span of publication (under the present format) this magazine has been widely recognized for its excellence, both in design and editorial content. *Colorado Medicine* has become a widely-read publication carrying selective general advertising of a medical and health-related nature. Your inquiries about advertising and/or editorial contributions are invited. There are many other member services provided by the Colorado Medical Society, in keeping with the purposes, as stated in the Constitution of this 112 year old organization.

The Colorado Medical Society Department of Membership Services invites your inquiries concerning these myriad other services. Please contact the CMS Membership Services, (303) 321-8590, or write Member Services, Colorado Medical Society, 6825 East Tennessee, Building #2, Denver, CO 80224.

* from the Constitution of the Colorado Medical Society, as amended through September 10, 1981

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Safety Belt Coalition Formed

Editor's Note: On June 7, the Colorado Medical Society, on the recommendation and endorsement of the CMS Board of Directors, joined with a number of other organizations to form a coalition to lobby for a Colorado mandatory seat belt law. The following article by Publications Editor Sheila Swan recounts some of the safety belt issues and activities which led to the forming of the coalition.

Seat belts save lives. To physicians, many of whom have seen first-hand what automobile accidents can do to victims, this statement has almost become an axiom. Yet did you know the following facts:*

- If seat belts were used by 70 percent of the population, 11,500 lives could be saved each year.
- 600,000 injuries could be prevented or reduced annually.
- Currently, there are approximately 40,000 highway fatalities each year, at a cost to American society of more than $40 billion. Only about 11 percent of Americans use seat belts.

The medical evidence shows that:

- Motor vehicle crashes produce more paraplegics and quadriplegics in the U.S. than all other causes combined.
- Major damage to the face from motor vehicle crashes is the leading cause of non-cosmetic plastic surgery.
- Such crashes are a major cause of epilepsy.
- Traffic crashes are the number one killer of American youth (under age 24).
- More than half of all road-related fatalities are car passengers who might have lived if they had used occupant restraints.
- Every six seconds, someone in the U.S. is injured in a motor vehicle collision, and an average of 137 persons die every day from such collisions.

When safety belts are used, however, they reduce death and reduce the severity and frequency of injury in vehicle crashes. According to the Motor Vehicle Manufacturers' Association, in head-on collisions and roll-over accidents, belt use has a dramatic effect in reducing fatalities by body area. For example, studies have shown that there are more than 80 percent fewer deaths from head injuries when belts have been worn.

Motor vehicle accident prevention is a world-wide problem. So far, 29 countries, including Great Britain, France, Australia and Israel, have passed mandatory seat belt laws.

On June 7, a meeting sponsored by the American Association for Automotive Medicine was held to review seat belt laws and a proposal to sponsor legislation within Colorado. Present at the meeting were physicians and representatives of numerous organizations, including the Colorado Medical Society, Colorado Highway Patrol, the American Association for Automotive Medicine, the Highway Users Federation, the Child Safety Seat Coalition, the Colorado Department of Highways, the Colorado Department of Health and the Colorado Public Health Association.

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The special guest speaker was Dr. Murray Mackay, Director of the Department of Transportation and Highway Engineering at the University of Birmingham, England. Dr. Mackay was instrumental in passing a safety belt law in Britain. In his discussion, he commented that despite a broad educational program, prior to the passing of legislation, only an average of 25 to 30 percent of the British population used seat belts. The law, applying only to front-seat riders, was passed in 1982 and enacted in January, 1983. Since then, usage has gone up dramatically, to between 60 and 70 percent, according to Dr. Mackay.

There has been an estimated 45 percent reduction in injuries. Additionally, approximately 400 million pounds has been saved in costs to police, hospitals and social and rehabilitation services.

Although it took a number of years to pass the law, Dr. Mackay said that it received strong support from the media and endorsements from many influential public figures, including racing drivers and soccer players.

He commented that "enforcement in Britain has not had to be at a high level," and no special policing has been necessary. Violators, if caught, receive a $30 fine.

Passive restraints were mentioned as a possible alternative to mandatory seat belts. However, Dr. Mackay pointed out that it would take 12 to 15 years for everyone to be equipped with passive seat restraints, since the entire car population would have to turn over.

At least 29 countries have passed mandatory seat belt laws.

Elaine Petrucelli, Executive Director of the American Association of Automotive Medicine, also spoke at the meeting. The association, with the Medical Society of New York, founded the New York Coalition for Safety Belt Use in 1982. A number of medical organizations and state agencies joined the coalition. According to Ms. Petrucelli, the association picked New York as the first state to try to pass a seat belt law, because traditionally it has been a "bellwether in health and safety issues."

The coalition also received strong support from the media, including the *New York Times*. Ms. Petrucelli noted that the chairmen of the transportation commissions of both the Republican and Democratic parties worked together to support the passage of the law. Surveys showed that 60 percent of the population of New York State favored the legislation. As a result of the coalition's efforts, in late June the New York State Assembly passed the nation's first mandatory seat belt law. As this is being written, Governor Cuomo is expected to sign the bill into law.

And what of Colorado? The representatives of the organizations at the June 7 meeting all agreed that the time is now to begin working for a safety belt law in Colorado. Thus a Colorado Safety Belt Coalition was formed. Dr. Denis Elo, a Loveland surgeon and active CMS member, was elected chairman *pro tem* of the group. Target date for passage of a safety belt law in Colorado is legislative year 1986 — two years from now, approximately the length of time it took to pass the law in New York. Will the law pass? Only time will tell. But, as was discussed at the June 7 meeting, medical society support was crucial in passing legislation in New York, as well as in several other countries, including Britain and Australia.

Will the people of Colorado support such a law? It has worked in many other democratic countries. New York, one of the largest states in the U.S. has passed such a law. It was pointed out at the meeting that we already obey an array of laws designed for our protection, including the licensing of drivers. A safety belt law may mean the difference between life and death for thousands of Colorado drivers and passengers. As Dr. Mackay stated, "Driving is not a divine right — it's a privilege."

*Sources: the National Safety Council, the National Highway Traffic Safety Administration and the American Association of Automotive Medicine.

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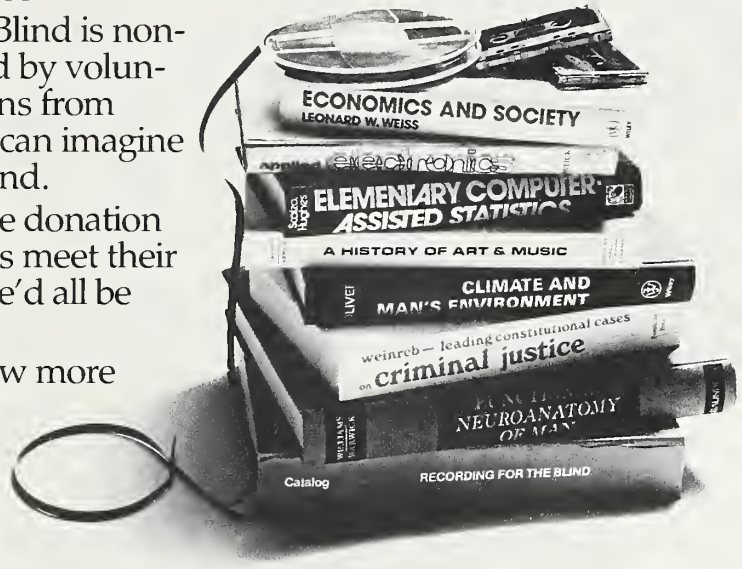
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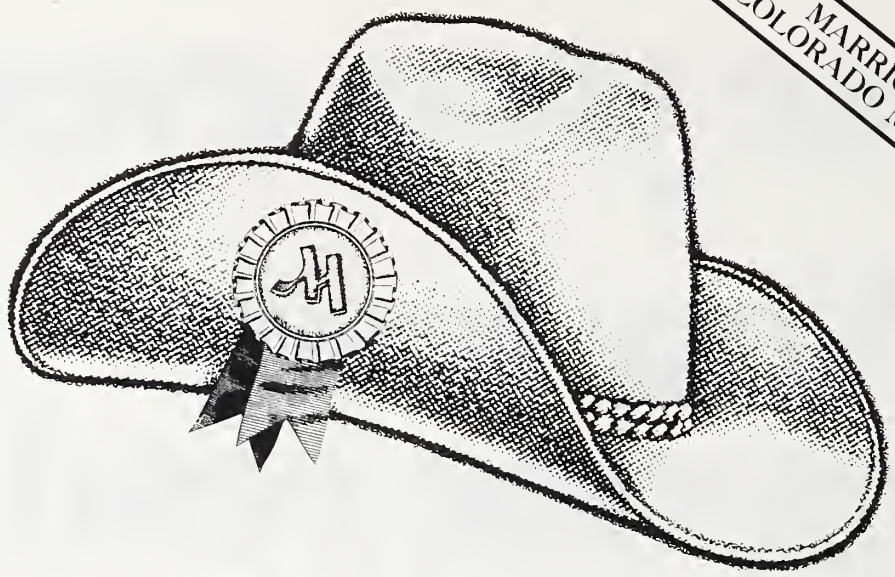


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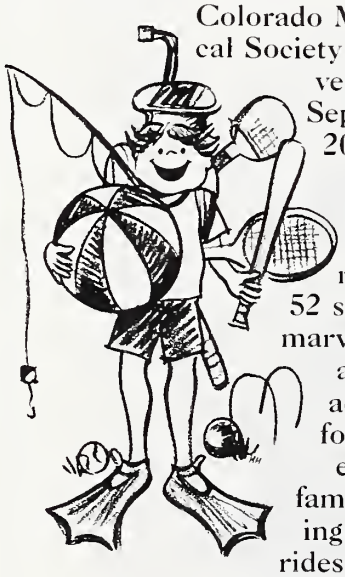
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The 1984 Scientific Program

This year's scientific program will focus on a broad array of economic issues facing medicine today. The current health care environment, featuring mounting pressure for cost cutting, proliferation of alternative delivery systems and reimbursement arrangements, and sharply-increased consumer awareness, can be most successfully confronted and used to advantage by the physicians most willing to adapt to the changes while still maintaining timeless values. Change is inevitable, but patient care must not be compromised.

The 1984 scientific program is designed to help you become more informed about these complex issues and thus, we hope, better-prepared to face them. A look at the schedule will reveal that an impressive group of national experts and representatives of different players in today's health care scenario has been assembled to address these concerns from a variety of perspectives. The panel session has been planned to provide time for both panelist interaction and audience participation.

On Saturday morning, for a refreshing change, we also have a special presentation on the Shroud of Turin for those interested in this fascinating phenomenon.

So mark your calendar for September 21 and 22 and plan to attend this excellent program. It promises to be one of the best we've ever had.

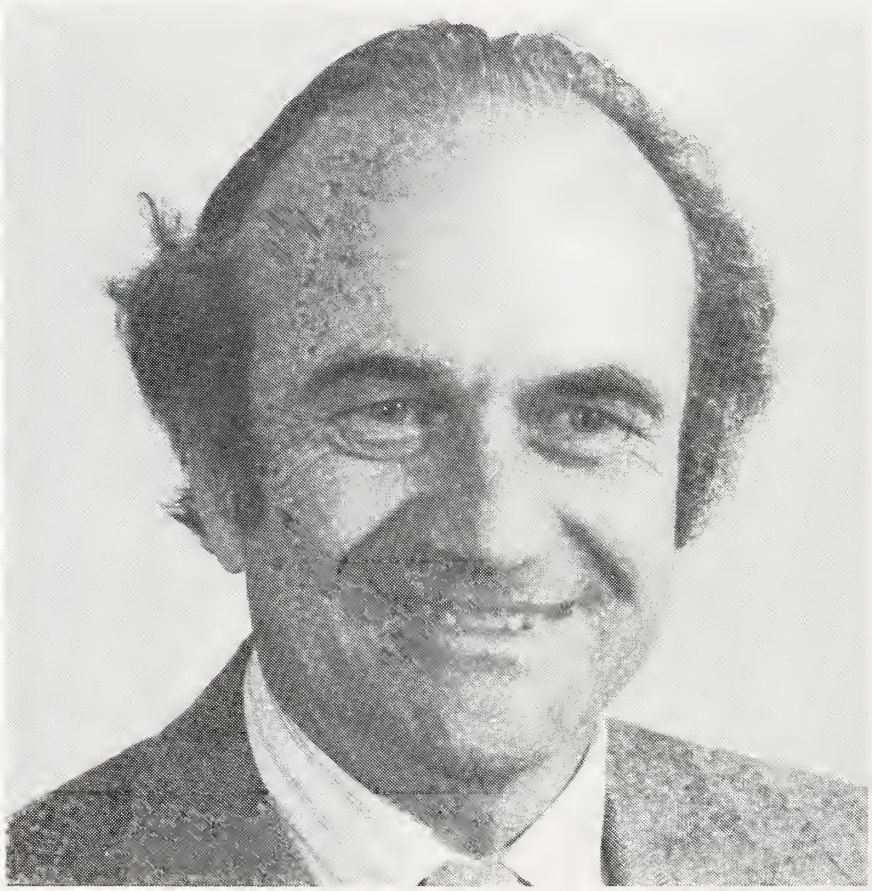
Arnold Greensher, MD
Program Chairman

David M. Haggerty
Director, Professional Services

Medicine in the '80s
Survival in an Age of Change

by Arnold Greensher, MD, Chairman, 1984 Scientific Program

Conventional wisdom would have it that the scientific program of a medical society not preoccupy itself with the economics and the future of health care. After all, this conventional wisdom says, the changes we are facing may be just a temporary swing of the great pendulum. As much as I was delighted to have the honor of being program chairman for this year's scientific progam, I shuddered as well. Something inside me groaned and remembered the age-old adage about the messenger who brought bad news. It would be easy to create another traditional program describing new technologies or treatments. Two hundred or 300 physicians would return home with only a small number needing the information and perhaps even fewer ever putting it to use. There is probably more than enough traditional continuing medical education available at each of our hospitals on a day-to-day basis. The State Board of Medical Examiners has even given up the task of having to police continuing medical education in this state and has removed the mandatory requirement. It would have been easy and certainly non-controversial to create the traditional program, but these are not traditional times and they certainly demand unconventional thinking and decision-making.



Arnold Greensher, MD, Chairman, 1984 CMS Scientific Program

1984, the Orwellian Year, will be long remembered in the history of American medicine. It is the year in which we exceeded the dreams of our English cousins and developed the complicated and arbitrary system of socializing not a profession but disease groups. Each disease entity is located in a group called a DRG with a fixed and equal payment to all hospitals treating it (more or less). Indeed, some might contend that DRGs are a firm outgrowth of democratic principles — that of giving each an equal share. This is the year that produced an even hastened pace of entrepreneurial endeavors in the health care field with further dramatic growth of emergicare, surgicare, birthing centers, and you-name-it. Interestingly, many of these ventures are not owned and operated by physicians but rather by investor groups with diversified backgrounds whose great incentive in such ventures is the "bottom line.'.

Having just returned from speaking at a series of national meetings that were devoted to finding "alternatives to the hospital," I was astonished to discover that the new entrepreneurial side of medicine was producing bottom lines of 20 percent to 30 percent in yearly profits on investments for those adventurous enough to invest in this highly volatile health care industry. Some of the financial speakers at these meetings felt that any return below a 20 percent to 30 percent profit would not make the investment a wise one. It is interesting to note that the for-profit hospital chains have seen similar growth and profits in the past several years. Not-for-profit hospitals would never imagine this kind of capital return and probably would consider 5 percent to 8 percent as an indication of financial success.

Who are the investors in this new era of the industrialization of American medicine? They are a very diversified lot, varying from individual investors, including some physcians, to mutual funds seeking high gain financial rewards. The American phi-

losophy of short-term financial rewards coupled with the public's perception (perhaps correct) that we are not really providing what they want or need produces a new medical market with many types of products. This new market place includes some problematic and often cost-ineffective alternatives to traditional care.

Somehow physicians in general have remained aloof from these ventures, feeling that they were passing fads, gimmicks, and intrusions into the practice of medicine. Now that the number of these entities has increased very rapidly and as their impact on traditional practice becomes obvious, we will most probably use our conventional means of dealing with something we don't like. This response will be to attack the quality of these non-traditional health care programs and finally ask the government to regulate them. It is ironic that we will be the ones asking for regulation.

If you believe that this plague will pass for lack of hosts, you are mistaken. Given the blossoming group of medical school graduates (and there seems to be no end to class size), it will not be difficult for any entrepreneurial venture to find physicians to staff alternative health care sites. It is even reasonable to expect that such facilities may provide the same quality of health care that a traditional physician's office does. Industry is very effective at analysing and defining the quality components they desire and shooting for them. On the other hand, I remind you of the success of the famous Ford Pinto in rear-end collisions.

These "gimmicks" could not exist if there were not consumer demand and satisfaction with the product they provide. At last year's scientific progam, Eric Berkowitz, presently Dean of the School of Business at Amherst University in Massachusetts, who spoke on marketing and health care, clearly demonstrated that today's public (the consumer of health care) is in no way like the public of five years ago. It becomes increasingly evident that the scope and speed of the changes around us will force us to change in the next several years. It is important to recognize that it probably will not take several years for the changes to have a significant impact on how we practice medicine and on our incomes.

Our traditional pattern of behavior is to retreat more deeply into our offices as danger threatens. This old strategy was rather successful in the past as indeed we were right — it was all just a temporary swing of the pendulum. The difference this time is that the pendulum has left its shaft. We can no longer persist in this ostrich behavior and will need to join forces to provide viable options for health care. If you're asking why we need to be the driving force in providing options for the future, the answer is rather obvious. Someone must continue to keep the patient's interest at heart. The cost of health care is easy to classify as excessive and cost-ineffective when one is well and has to pay for someone else's health care. It is amazing how that response changes when one becomes a patient and one's own health care is being cut. We are faced with the difficulty of justifying the high cost of organ transplants which now give patients several or more years of additional life and justifiably do not think twice about spending vast sums to treat patients with incurable diseases such as cancer. The ethical and financial issues involved in health care in America cannot be solved by a "quick fix" approach and certainly not with a corporate approach which in the past has led to pollution of lakes and streams, the loss of our forests, and the rapid and wasteful depletion of many of our natural resources.

There are several not mutually exclusive rallying points which include the hospitals and our medical societies. Hospitals are now caught in the crossfire between other hospitals and their medical staff. The feeling that hospitals are still "the enemy" is a pervasive one in our profession. This feeling has been reinforced in the past two years as hospitals become more involved in the dynamics by which patients get their health care. There is no question that hospitals are involved in a highly competitive process that will become increasingly intense. For most hospitals the issue is one of survival. Their response is to meet the challenge with new creative ap-

(Continued on p. 208.)

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Preliminary Program
1984 CMS/CMSA Annual Meeting
September 20-22, 1984
Marriott Mark – Vail, Colorado

Wednesday, September 19

9:30 am - 1:00 pm	Medical Executives Group
11:30 am - 1:00 pm	CMS Finance Committee
1:00 pm	CMS Board of Directors
1:00 pm - 5:00 pm	CMS Hospital Medical Staff Section
4:00 pm - 6:30 pm	Registration
6:30 pm	Welcome Reception Hosted by Marriott Mark

Thursday, September 20

7:00 am	Registration
7:00 am	Prayer Breakfast
7:00 am	Constitution, Bylaws and Credentials Committee
8:00 am - 5:00 pm	CMSA Hospitality Area
8:00 am - Noon	House of Delegates (CFMC Corporate Meeting)
9:30 am - 4:30 pm	Country Store - CMSA
10:00 am - 12:30 pm	CMSA House Tour
Noon	Reference Committee Chairmen Luncheon
Noon	CMS Past President's Luncheon
1:30 pm	Reference Committee Hearings
2:30 pm - 4:00 pm	CMSA County Presidents/ President-elects
4:00 pm	Exhibits Open
4:30 pm - 6:30 pm	Exhibitors Reception in Exhibit Area
6:00 pm - 7:30 pm	CMSA Reception - Honoring AMAA President-elect, Mary Kay McPhee
7:00 pm	Specialty President's Dinner Meeting (By Invitation Only)

Friday, September 21

7:00 am	Registration
8:00 am - 4:30 pm	Exhibits
8:00 am - 5:30 pm	CMSA Hospitality Area
9:30 am - 4:30 pm	Country Store - CMSA
8:30 am - 3:30 pm	Scientific Progam - "Changing the Face of Medical Practice"
8:30 am - 9:30 am	Health Care Services - The Evolving Competitive Marketplace
9:30 am - 10:30 am	Consumers' Views of Medical Care and Medical Costs • Hospitals • Business and Industry • Medical Insurance Carriers • HMOs/PPOs/IPAs
10:30 am - 11:00 am	BREAK (exhibit area)
11:00 am - noon	Panel continues
11:45 am - 1:00 pm	COMPAC Luncheon
1:30 pm - 2:30 pm	The Role of the Medical Profession in the Emerging Integrated Health Care Organization
2:30 pm - 3:30 pm	Impact of the Future on Medical Practice Sponsored by CMSA
6:30 pm	Presidents' Reception
8:00 pm	Presidents' Dinner

Saturday, September 22

8:00 am - 3:00 pm	CMSA Hospitality Area
8:00 am	Registration
8:00 am - Noon	Exhibits
8:30 am	CMSA Open Board Meeting
8:30 am - 11:00 am	Scientific Program - Workshops (Three Concurrent Sessions) • DRGs and the Hospital • The Ethical Implications of Rationing and Cost Containment - Impact on Medical Practice • Recent Scientific Investigations of the Shroud of Turin (John Jackson, Ph.D., Vice-President, Shroud of Turin Research Project)
9:00 am - 2:00 pm	Country Store - CMSA
10:00 am	CMSA General Membership Meeting (Installation of Officers)
Noon	CMSA Annual Luncheon
1:30 pm	House of Delegates
2:00 pm	CMSA Incoming Board of Directors Meeting
Immediately Following Adjournment of House	CMS Board of Directors Reorganizational Meeting

Continuing Medical Education

CALENDAR

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August, 1984

1-5 **25th Annual Advanced Seminars in Dermatology** — Hyatt Lake Tahoe, Incline Village, Nevada. Credit: 20 hours AMA/CMA Category I. Fee: $250 for non-University of Calif. physicians. Contact: Jane A. Johnson, Office of Continuing Medical Education, School of Medicine, TB 150, University of California, Oavis, California 95616. (916) 752-0328.

2-5 **Third Annual KU Summer Medical Symposium Medicine For The Practicing Physician** — The Broadmoor Hotel, Colorado Springs, Colorado. Credit: 12 hours AMA Category I; 12 hours AAFP; 12 hours AOA Category 2-D. Fee: $325. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103, (913) 588-4480.

4-5 **Pediatric Sports Medicine** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 9.5 hours Category I AMA, 9.5 prescribed AAFP hours; 9.5 hours AOA Category 2-D. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

6-9 **27th Annual Pediatric Program** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 21 hours AMA Category I; 21 prescribed hours AAFP; 21 hours Category 2-O. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

6-10 **International Symposium on Hand Surgery** — Marriott Mark Resort, Vail, Colorado. Sponsored by the Colorado Hand Surgery Education and Research Foundation. Speakers will include physicians from the U.S., plus the following: Drs. Juan Fernandez, Mexico; Guy Foucher, France; Oamian Ireland, Australia; Neville Kay and Thomas Wadsworth, England; Ulrich Lanz and Lennart Mannerfelt, West Germany; Borje Sundell, Finland; Tatsuya Tajima, Japan; Ravin Thatte, India. Contact: Or. John A. Boswick, University of Colorado Health Sciences Center, 4200 E. 9th Ave., Box C-309, Oenver, Colorado 80262. (303) 394-8718.

8-9 **High On The Foot** — Marriott Mark Resort, Vail, Colorado. Credit: 13 hours AMA Category I; 13 prescribed hours AAFP, 13 hours AOA Category 2-D. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

9-11 **38th Annual Rocky Mountain Cancer Conference For Medical Professionals** — Fairmont Hotel, Denver, Colorado. Seminar will be a lung symposium in honor of Geno Saccomano, MD. Co-sponsors of the program are the American College of Chest Physicians and the American Lung Association. Registration deadline: August 1. Contact: Chris Heminway, RN, American Cancer Society, 2255 South Oneida, Denver, CO 80224, (303) 758-2030.

9-12 **10th Annual Primary Care Orthopedics** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 21 hours AMA Category I, 21 prescribed AAFP hours, 21 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

12-14 **Primary Care of the Back** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 14 hours AMA Category I, 14 prescribed AAFP hours, 14 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

14-18 **Kidney Disease, Hypertension and Disorders of Fluids and Electrolytes** — Given Institute of Pathobiology, Aspen, Colorado. Credit: 19 hours AMA Category I, 19 prescribed hours AAFP; 19 Category 2-D AOA hours. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262, (303) 394-5241.

20-22 **VIII International Congress on Hyperbaric Medicine** — Hyatt Regency Hotel, Long Beach, California. Conference will include original papers, exhibits, poster presentations and plenary sessions. Contact: The Secretariat, VIII International Congress on Hyperbaric Medicine, % Baromedical Dept., P.O. Box 1428, Long Beach, CA 90801-1428, (213) 595-3613.

22 **Mammography** — Julesburg, Colorado. Speaker: Edward E. Callaghan, MD. Credit: 2 hours AMA Category I and 2 AAFP prescribed credit. Contact: Martin J. Rubinowitz, MO, The Denver Clinic, 701 E. Colfax Ave., Oenver, CO 80203, (303) 831-7171.

27-31 **University of Colorado Internal Medicine Board Review Course** — Oenison Auditorium, University of Colorado School of Medicine, Oenver, Colorado. Credit: 44 hours AMA Category I. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Oenver, CO 80262, (303) 394-5241.

30-1 **32nd Annual James J. Waring Chest Conference** — Longs Peak Inn, Estes Park, Colorado. Contact: Shirley Lindquist, American Lung Association of Colorado, P.O. Box 921, Loveland, CO 80539, (303) 667-5198.

Drug Therapy Q & A

This bimonthly column is designed to provide Colorado physicians with specific answers to commonly-asked questions about drug therapy. The column is prepared by the staff of the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column are generated by calls received by the Rocky Mountain Drug Consultation Center from physicians and other health professionals.

Physicians are encouraged to call the Rocky Mountain Drug Consultation Center at 893-DRUG in the Denver metro area or 1-800-332-6475 in other areas of Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure, and drug identification. The center is available from 8:00 am to 5:00 pm Monday throug Friday, with 24-hour on-call service.

The director of the Rocky Mountain Drug Consultation Center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center and the Medical Director is Earl Sutherland, MD, PH.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center.

The authors of this month's articles are Larry K. Golightly, Pharm. D. (Iron Staining of Teeth) and Cynthia J. R. Gelman, BS, R.Ph. (Cimetidine — Therapy of Herpes Zoster).

Iron Staining of Teeth

Request: A two-year-old girl has developed an ashen grey color of the teeth. This discoloration is most prominent on the gingival third of the upper anterior teeth. The child takes liquid iron supplements daily. Could this be drug-related and if so, what can be done to remove or lighten the stain?

Response: The most commonly-used liquid iron supplements, including pediatric drops and syrups (e.g. Fer-In-Sol) are sweetened, alcoholic solutions of ferrous sulfate. Official formulations of these products are dark brown liquids with a pH in the range of 2.0 or less[1].

Serious dental complications from oral iron therapy are rare. However, extensive erosion and staining of anterior teeth have occurred from prolonged contact of tooth surfaces with sugar-sweetened, acidic iron supplements when administered in "pacifier" nipples[2]. This usage is somewhat analogous to the problem of nursing-bottle caries[3] and is no doubt due to combined actions of acid, excessive growth of oral bacteria due to the sugar content of the solution, and prolonged contact with teeth.

Iron solutions can stain teeth. In vitro studies using extracted human premolars have demonstrated that visible color changes and staining are imparted to teeth when placed in solutions of metallic ions including iron compounds[4]. In this investigation, iron staining occurred more prominently in areas where tooth enamel was defective or intentionally etched. Acidic solutions increased staining and increased uptake of metallic ions into tooth structures. Exposure to sulfide (which is released naturally from saliva and some foods) resulted in a marked darkening of tooth surfaces. Similarly, studies in animals have clearly shown that iron solutions stain teeeth brown to black when applied topically or when given in drinking water; in this experiment, iron supplements appeared to reduce plaque formation and, interestingly, slightly decreased development of caries[5]. Thus, superficial staining by iron is unlikely to weaken dental enamel.

In clinical usage, noticeable staining of teeth occurs commonly with liquid iron products, whether given in the form of antiseptic or caries-preventing mouth rinses[6,7] or as nutritional supplements[2,8,11]. Available evidence indicates that this staining is typically extrinsic, involving the surface enamel. Iron or iron sulfate can bind to teeth, attached by mucinous or colloidal films, and may collect in plaque and other debris on tooth surfaces, thereby increasing discoloration. Unless tooth structures are defective or laden with caries or pre-carious lesions, staining usally does not invade tooth structures. Tooth surfaces are generally smooth and caries rates are low in the anterior teeth which suggests that the probability of intrinsic (deep) staining of anterior teeth is also low.

Superficial discoloration of teeth caused by liquid iron preparations can usually be prevented or removed by proper oral hygiene[2,9]. Regular, frequent brushing will remove plaque and slowly lighten stained teeth. One manufacturer of liquid iron supplements further suggests that staining may also be removed by rubbing the teeth with a little baking soda (sodium bicarbonate) on a small cloth once a week[12]. Some authorities recommend diluting oral liquid iron preparations with water or fruit juice and administering these solutions through a drinking straw to minimize contact of the solution with teeth. These recommendations are probably reasonable, since recent in vitro studies have shown that degree of staining is proportional to concentrations of iron in dental rinses[13]. Administration of oral iron tablets does not cause discoloration of teeth[14].

In summary, oral iron solutions may superficially stain healthy teeth. Staining can usually be prevented or removed by proper oral hygiene

measures.

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Cimetidine — Therapy of Herpes Zoster

Request: Is cimetidine useful for treatment of herpes zoster?

Response: Considerable interest in the use of cimetidine for the treatment of pain and pruritus associated with herpes zoster has occurred due to several recent reports in the medical literature. These reports have been widely publicized in the lay press.

Relief from pain and pruritus and a decrease in time to healing and scaling of skin lesions has been described in small numbers of patients who received 1200-1800mg cimetidine daily. In the communication by Mavligit and Talpaz[1], cimetidine was being utilized as an immune-restorative biologic-response modifier in cancer patients. They serendipitously noticed "dramatic" relief in pain and pruritus as well as healing and scaling of skin lesions of a concomitant herpes zoster infection in four patients. Improvement was seen by day two of cimetidine therapy.

Hayne and Mercer[2] described one patient who began receiving cimetidine on the seventh day of the active phase of a herpes zoster infection. After two days of cimetidine, the newest sites were drying and erythema was reduced.

Similar results were reported in 1980 by Van Der Spuy et al[3]. They treated 21 cases of herpes zoster with cimetidine 1600mg for two days, then 1000mg for five days. Encouraging results were produced in 18 patients. Effects on post-herpetic neuralgia were reported in only a single patient; in this individual, the drug provided no improvement in symptoms of neuralgia.

Conclusion: Anecdotal results have described beneficial effects from cimetidine in reducing time of healing, pruritus and pain in patients with herpes zoster. Larger controlled trials are necessary to determine if cimetidine has a role in the management of this disease.

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Drs. Say No

(Continued from p. 191.)

openly with their patients, identifying conflicts in medical-ethical issues and providing awareness of social responsibility?

- Why do we, by our silence, seem to condone the practice of some of our members engaged in scientific research who patently falsify their results to advance their own careers?
- Have we addressed the question of the ethics involved when physicians engaged in basic scientific research, in the employ of industry, accept the prescription to keep their research secret — not to share the discovery — even though that may mean that a major advance in the diagnosis or treatment of disease may be denied the general public for years, if not forever?
- Have we addressed the question of whether our teaching institutions ought to accept research grants from industry when restrictions on the use of that research come along with the grant?
- Should we not loudly and clearly be encouraging our local medical associations to seek the means whereby they can review fee practices of some of their members, rather than withdrawing from the arena?
- Are we willing to pledge substantial portions of our assets to stand behind those scientific societies that are willing to establish standards of practice that will protect the public from the incompetent practitioner?

It is my judgment that if we proceed in a deliberate and conscientious fashion, committing ourselves to an ethical standard for medical practice which is intended to serve our primary goal and protect the interest of individual patients; if we do not succumb to the notion that the individual doctor will become the agent to decrease access or availability or diminish quality in the cause of saving hospitals; if we state clearly that we will not surrender to attorneys or courts the practice of good medicine; if we pledge not to leave to the courts decisions best made by patients, their families and their physicians, if we can begin with our own behavior and commitment to provide appropriate role models for medical students and physicians in training; if we seriously address the question of the conflicts between the needs of patients and the needs of corporate enterprise, both in the provision of care and the process of research; then we will have taken a long step along the path which leads to real progress in medicine instead of a retreat into mediocrity.

Survival

(Continued from p. 203.)

proaches to the changing health care scene. Practicing physicians often see this rapid change by hospitals as contrary to their interests. Indeed, sometimes the hospitals' efforts do affect the practices of the very staff physicians whom the hospital serves. In the face of a potential crisis, with the need to undertake new programs, there is an inherent risk of making some moves that will not please everyone. Rapid change has an uncanny ability to bring about conflict. In the turbulence of our times there is no doubt that we will continue to face even more rapid change and increasing conflict.

It would be a monumental error for us to further the conflict between physicians and hospitals because of perceived and sometimes real "wrongs". Divisiveness at this time will not produce what we as a profession and our patients need. Mistrust, confusion, denial, anger and retribution will indeed permit our house to fall into the hands of the architects sitting in Washington who are known for paying $400 for a screw — (no pun intended) while they turn around and put the screws to a nation's health care. We do not have a lot of time to sit around and see what happens. Things will move too quickly for that. This is a time in which all of us need to become involved at both the hospital level and the medical society level. Hopefully this involvement will not take place in a conflict and adversarial mode but rather in a spirit of developing mutual goals and efforts. We must understand that we all may have to give up a little to gain some control over an uncontrolled situation.

This year's scientific program is more than a sounding board, it will be raw, hard reality and facts. We all need to hear the facts so that we may begin to respond effectively. I look forward to your participation in this year's meeting.

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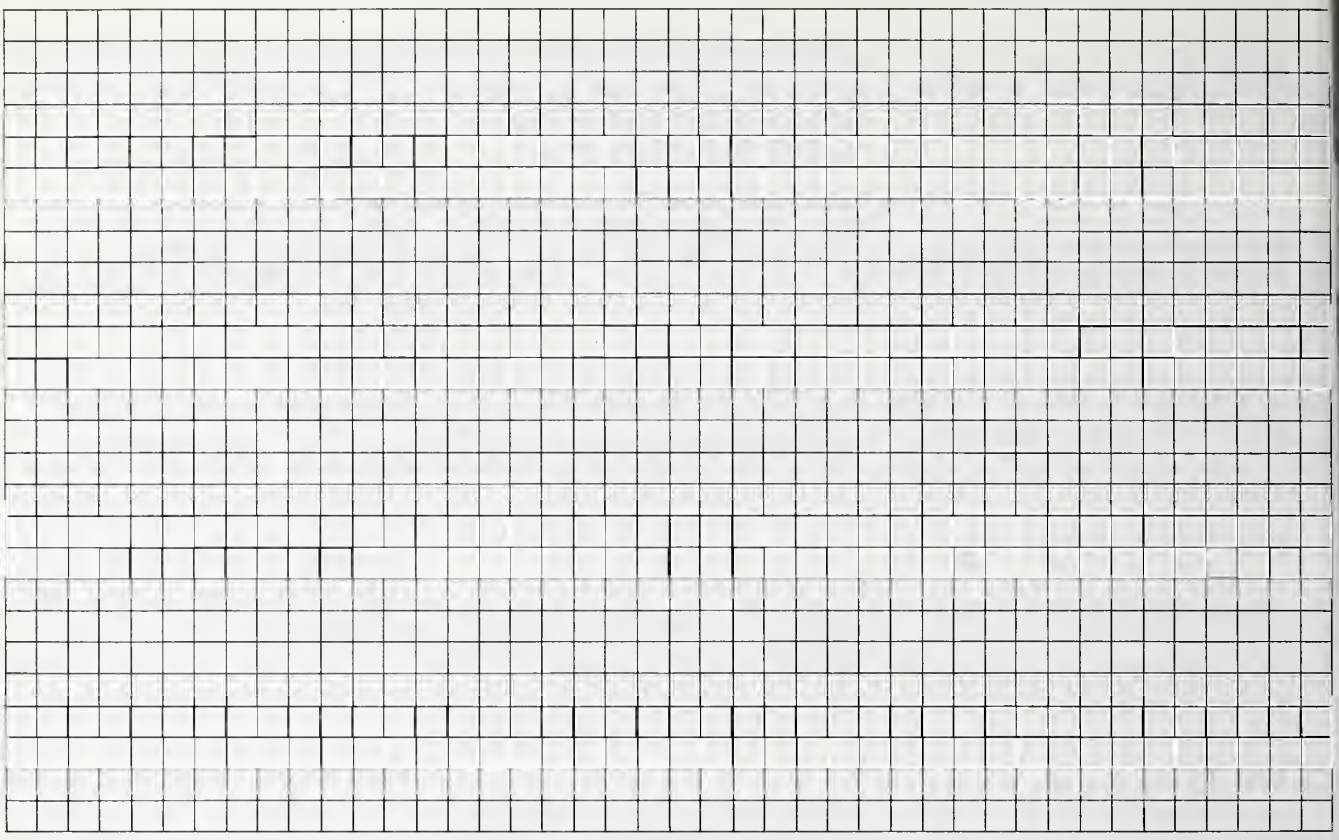
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This Month's Cover:

The COPIC Trust has grown and changed — now the COPIC Insurance Company is a reality! The September issue of *Colorado Medicine* discusses the evolution of COPIC: how it started, how it has grown, where it is now, and where it is going. Read this informative article by K. Mason Howard, MD, Chairman of the COPIC Board of Trustees. Other articles (by Larry Thrower, COPIC President and Steve Cohen, Vice President) will tell you about the programs and services, old and new, which COPIC offers and discuss how the malpractice insurance industry has changed — and what this means for Colorado physicians.

Also this month, *Colorado Medicine* brings you the farewell messages from outgoing CMS President John A. Whitesel, MD and Auxiliary President Bunkie Inkret. Dr. Whitesel and Mrs. Inkret discuss the problems and satisfactions, goals and achievements of their year in office.

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president's letter



John A. Whitesel, MD
President, Colorado Medical Society

Au Revoir!

This is my last President's Letter to you. The '83-'84 CMS year has been quite lively and eventful. Having been asked to serve you, I hope that I have served you well. The experience will always remain an important part of my life. Friends have asked me several times, "was it worth it?" Although the time commitment was significant, the burden heavy and the solution to some of our problems unclear at times, I can answer emphatically "yes", since through our joint efforts we have made significant steps forward this year.

Our positive action this year included establishing the medical staff section, the membership committee, long range planning committee and emphasis on development of non-dues income. We established the CMS/ERF fund that will benefit members and students for many years to come. Additionally, a past president's commission was formed.

All the accomplishments of the councils and committees are too numerous to mention, but they include bills for tort reform and opposition to bills that would result in losses to the quality of medical care. The Colorado Medical Practice Act will be subject to review this year under the sunset law and your society will again support you by representing your interests at the legislature.

CMS joined with three school districts and the Colorado High School Activities Association in a lawsuit brought by the chiropractors. CMS supports the association's bylaws which require that a medical doctor conduct physical examinations for student athletes.

We have involved ourselves in the community in regard to medically indigent care and have had meetings with senior citizen groups to address their needs.

Increased communications to the membership was begun with a "state of the society" report. The Admministrative Advisory Committee was established to bring component leaders as well as board members into the administrative process.

Constructive relations with the press have been further developed this year, e.g. by giving the media information on medical issues so that medicine develops an appropriate image in the media and we're not just reacting to news coverage.

The building project has received an abundance ot time and energy by all. Your leadership is pursuing the best solution to this situation, considering all the possibilities, with a real estate/developer consultant. This solution should be presented to you shortly.

The Colorado Foundation for Medical Care has suffered a significant loss with the death of Mr. Peter Samac. Although its present leadership is equal to the task, the Foundation faces an almost impossible job in the government review process this next year because of drastically-reduced funding and an increased scope of work. They will need your understanding and support.

My greatest goal for our organization—unity of purpose and action—is approaching reality at the end of a year that has found us separated on many significant issues. I have been told that "unity must be earned," with which I most heartily agree. Like a marriage, unity as well as mutual respect and cooperation have to be worked on every day. In order to achieve my dream for the society, I solicit your support and daily practice of these elements and others which will cause unity to grow and become our greatest asset.

Freedom can live in the same house with unity as long as we recognize what freedom means in an organization which is attempting to accomplish creditable goals and solve difficult problems. Freedom means that a member within our organization has the mechanism at his or her disposal to express his or her views, work actively from them and see them approved or disapproved by the majority. It does not mean unrestricted license to work outside the democratic process, attempting to put unapproved ideas into motion or to disrupt the approved programs and goals. This is not the definition of freedom in an organizational sense. If such a climate occurs, impotence and strife result.

And so, my friends, I bid you a fond farewell and free you at last from my philosophical renderings, but not my best wishes and continuing support for a strong and health Colorado Medical Society and state of Colorado.

Aurora Physician Suite Available

Mississippi II Medical Center has suite opening October 1st. Five exam rooms, office, lounge, lab and extras. Share waiting room with X-ray unit. Building currently has 4 OB-GYNs, 3 Optometrists, Family Practitioner, Internal Medicine, Ophthalmologist, Podiatrist, Physical Therapy, Dentist and Pharmacy.

Call Bill Wildman, Western Medical Management 344-0010

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auxiliary report



Bunkie Inkret, President
Colorado Medical Society Auxiliary

1984: A Year of Success for the Auxiliary

September marks the end of one auxiliary year and the beginning of a new one. When I took the office of the presidency last October at Tamarron, ideas, hopes and ambitions were bubbling within me.

Fortunately, I have not been disappointed; many of the goals that were established and the visions hoped for have become reality. They were attained through the generous donation of time and talents by auxilians throughout the state. These goals also took place because the Colorado Medical Society officers and board fulfilled their jobs with enthusiasm.

This past year, I have encouraged increased communication between auxiliaries and societies at both the county and state levels. I believe this benefits both organizations. For example, the auxiliary is represented on many of the committees; we are thus aware of the projects we can undertake.

Participation '84 was one of the areas in which the auxiliary was active throughout the state. We have significantly increased voter registration among physicians and their families. One of our members represented Colorado at a recent meeting of the Med Vote Program in Washington D.C. This project's motto is "Don't sit out this election" but do let the voice of medicine be heard at the polls.

The auxiliary has also been active in organizing a group that will work with the Physician Health and Rehabilitation Committee.

We have been participating in the Prescription Drug Abuse Task Force and will work in the education program of that project.

The Private Health Insurance Committee has an auxilian representative to emphasize the needs of the families of the physician.

The Shape Up For Life program calls attention to the unborn and the newborn, and we will work through the CMS Public Health Council to educate prospective mothers on the dangers of smoking and alcohol consumption during pregnancy. We hope to reduce the problems, such as low birth weight and fetal alcohol syndrome.

These are a few of the areas in which we have been active. Last year when I took office I asked that we encourage programs in preventable diseases and increase solidarity in families. Our programs are helping to fulfill these goals. I believe that the health and welfare of our own families and all the citizens of our state will benefit from our involvement.

So I say "thank you" to the officers and committee chairmen of the CMS Auxiliary, to all the auxilians statewide, and to the national auxiliary for its guidance. But most especially, I thank the president and president-elect of the Colorado Medical Society, to the Board of Directors and to the physician members of the society for your support and encouragement. I am also grateful to the CMS staff for their cooperation and work in helping us to accomplish our goals.

This year has been rewarding and educational; however, my year as president is now past. It seems appropriate to share these words of Kahlil Gibran from his writing, *The Two Cities.*

Life took me up on her wings and bore me to the top of Mount Youth. Then she beckoned and pointed behind her. I looked back and saw a strange city, from which rose dark smoke of many hues moving slowly like phantoms. A thin cloud almost hid the city from my gaze.

After a moment of silence, I exclaimed: "What is this I see, Life?"

And Life answered: "This is the City of the Past. Look upon it and ponder."

And I gazed upon this wonderful scene and I saw many objects and sights: halls built for action, standing giantlike beneath the wings of slumber; temples of talk around which hovered spirits at once crying in despair, and singing songs of hope... theatres upon whose boards Life had acted out its play, and Death rounded out Life's tragedies.

Such is the City of the Past... in appearance far away, though in reality nearby — visible, though barely, through the dark clouds.

Then Life beckoned to me and said, "Follow me. We have tarried here too long" And I replied, "Whither are we going, Life?"

And Life said, "We are going to the City of the Future."

And I said, "Have pity on me, Life. I am weary, and my feet are bruised and the strength is gone out of me."

But Life replied, "March on, my friend. Tarrying is cowardice. To remain forever gazing upon the City of the Past is Folly. Behold, The City of the Future beckons..."

guest editorial



Bob O'Dell, MD

Is Credit Available For First-Hand Continuing Medical Education?

Medical educators highly recommend "hands on" experience as a necessary part of one's graduate education and continuing medical education (CME). Rat labs, dog surgery, gross anatomy, use of plastic models to practice endoscopy of all kinds are commonly employed to provide physicians with the expertise they need before beginning to examine and treat human patients.

But what about "first hand" educational experiences?

On Monday, July 23, 1984, at 1 a.m., I had an emergency appendectomy. Wow! My understanding of the symptoms, diagnosis and post-operative care and recovery has greatly increased. I think the same can be said of my surgeon, a long-time colleague with whom I have discussed many belly aches and with whom I have removed a number of appendices, both diseased and normal.

First of all, I'll discuss the importance of the development of symptoms. My "indigestion" started an 6:30 p.m. on Sunday in my mid-upper abdomen. It was totally unaffected by antacids and Zantac, treatment that usually gives relief. Heat was no help and, one hour after the attack started, my temperature was normal, although I had giant chills (the teeth-chattering kind) for about two hours after the attack started. I was never the least bit nauseated — a symptom almost always required before a diagnosis of appendicitis is made. After three hours, the pain and tenderness had spread to the right lower quadrant and my temperature rose to 102 degrees. Time for hospital, surgeon and white blood count.

An aside: how terrifying it must be to a layman to consider his first entry into the health care system when he is already acutely ill. I was overwhelmed and on the verge of tears several times as I experienced first-hand the skill, care and consideration so readily available to me when I needed them. A phone call produced a trusted surgeon, a competent hospital and skilled professionals who were waiting to serve me long before I arrived in the emergency room. The operating room staff cheerfully got out of bed to attend me and my whole ordeal was lightened by the very young x-ray technician who looked at my chart, then at me, and asked, "Are you really 53 or were you born in '53?"

A white blood count of 15,500 with left shift and an x-ray showing a calcified mass in the right lower quadrant confirmed our diagnosis and surgery was scheduled as soon as possible. Even then I learned something new: a half ounce of strong antacid (Tricitrate) was given me to drink. Now if I aspirated at any time during the procedure, no acid would burn my trachea and bronchi. This was a new procedure since I last assisted with surgery.

Surgery was uneventful, but interesting, so I was told. The appendix was acute and had a small area of gangrene due to pressure from a calcified fecalith in its lumen (the right lower quadrant mass seen on x-ray). Some peritoneal contamination had occurred, so intravenous antibiotics were added every six hours to my continuous intravenous.

After I awoke from anesthesia, my education continued. Everything hurt! Abdominal pain is not always improved after appendectomy, especially if peritoneal contamination has occurred. Everything inside feels sunburned. Muscles ache. The depolarization chemical used for muscle relaxation causes muscles to be sore, even in the athletically-fit, and sore calf muscles can easily be confused with deep vein thrombosis.

However, the pain was controlled very well by two suggestions I had made to the surgeon before falling asleep. I wanted an ice bag on my wound and a pillow under my knees. The ice prevented swelling, bleeding and pain at the incision site and the pillow relaxed my rectus abdominus and eased the intra-abdominal pain. My surgeon says he learned something new about post-operative care. I needed no shots or oral pain medication the first day after surgery.

Then the educational process continued. I began to have gas pains (somewhat relieved by regular grunting on my part); developed audible bowel sounds and even passed a little gas about 15 hours after surgery. I was encouraged and decided to try some of my clear liquid supper. The dark brown broth looked good, so I drank most of it, along with a little hot tea and a spoonful of jello. I learned several things from this. First, the broth was too salty, spicy, or something and did not pass through my stomach. It stimulated much stomach acid to be produced. Later on, when I became bloated and nauseated, I vomited sour, brown liquid and was sure I had developed a stress ulcer which was bleeding. A vision of naso-gastric tubes, ice water lavage and gastro-

(Continued on p. 219.)



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First-Hand

(Continued from p. 217.)

scopic examination almost prevented my calling the nurse, but reason prevailed. She came and tested the vomitus which was hemoccult "negative." Greatly relieved, I asked her to call my surgeon and request Tagamet, refill my ice bag and give me a pain shot. I slept like a baby the rest of the night.

Lessons learned:

1. Post-operative patients on intravenous still produce gastric acid. Intravenous or oral antisecretory medication (such as Tagamet) should be considered routine for such patients until significant stomach and intestinal activity has been established.

2. First offerings of clear liquids should avoid salty, spicy broths and anything brown in color. Bouillon, tea, coffee, etc., if vomited may look like blood and cause undue anxiety.

My recovery was uneventful thereafter and I was discharged on Wednesday morning. (Surgery had taken place at 1 a.m. on Monday, discharge from hospital at 10 a.m. Wednesday.) Many people at the hospital expressed concern that I was going home too soon, but the situation emphasized a fact that we all know: Patients with no secondary incentive to be ill get well faster. I have done well post-operatively and only missed one week of work at the office.

A footnote: My discharge instructions included one which said, "no heavy lifting or driving for one month." The nurse who escorted me to the exit and I both laughed heartily as I fetched my own car from the parking lot and drove myself home. Discharge instructions should bear some relationship to reality.

So I learned a lot about the care of appendectomy patients and so did my surgeon. Now, how do we apply for continuing medical education credit?

WHAT IS THE COLORADO MEDICAL SOCIETY?

The Colorado Medical Society is an association of professionals which:

"Promotes the science and art of medicine, the betterment of public health, and the welfare of the medical profession and the patients it serves; and promotes the similar interests of its component and district medical societies."*

Through the variety of physician councils and committees, the Colorado Medical Society continually monitors public health concerns, proposed legislation relating to these and other health issues, recommends legislation which will work toward the betterment of public health and welfare of the medical profession and the patients it serves.

In providing a continuing professional lobbying staff, the Colorado Medical Society keeps its physician members abreast of all current issues before the Colorado General Assembly and the Congress of the United States.

With regular publications, CMS is also able to inform members of pending and current actions as taken by the CMS Board of Directors and the Society leadership.

Colorado Medical Society yearly publishes the Physician's Directory, the most complete physician referral guide for private practice physicians, health care and medical education institutions, legal and insurance professionals, federal, state and local government offices and agencies.

A continuing program of public health information is conducted by the Colorado Medical Society and the Colorado Medical Society Auxiliary, working closely with public, private and parochial schools for the most complete program of health education and health awareness among primary and secondary school students.

Colorado Medical Society provides its own members with a continuing medical education program, year-around, involving numerous areas of specialty practice and general medicine. Such continuing medical education classes, seminars and symposia are accredited, and are announced in the monthly CME Calendar published jointly by the Colorado Medical Society and the Colorado Foundation for Medical Care.

Colorado Medicine is the official journal of the Colorado Medical Society, and in its short span of publication (under the present format) this magazine has been widely recognized for its excellence, both in design and editorial content. *Colorado Medicine* has become a widely-read publication carrying selective general advertising of a medical and health-related nature. Your inquiries about advertising and/or editorial contributions are invited. There are many other member services provided by the Colorado Medical Society, in keeping with the purposes, as stated in the Constitution of this 112 year old organization.

The Colorado Medical Society Department of Membership Services invites your inquiries concerning these myriad other services. Please contact the CMS Membership Services, (303) 321-8590, or write Member Services, Colorado Medical Society, 6825 East Tennessee, Building #2, Denver, CO 80224.

* from the Constitution of the Colorado Medical Society, as amended through September 10, 1981

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letters to the editor

Is CMS Afraid of Freedom?

To the editor:

Why is the CMS afraid of freedom? In the July issue of *Colorado Medicine* there are three letters concerned with the freedom to choose between society memberships. Dr. Whitesel writes the word "unity" six times in his president's letter and mentions freedom not once. Dr. Glode dramatizes the modest request of the DMS as a "holdup" and a "shootout," as if the DMS were an enemy and the bad guys at that. He makes the usual exhortation that the medical profession is besieged (it is), so therefore we must stay joined together and "speak as one voice."

For years of "unity" DMS and CMS have never spoken as one voice, and for the future it might even be better if some of our assailants hear two voices saying the same things as friends for a change. What we both need is more convincing voices from new members who will freely join both societies when it is made easy for them to do it.

Dr. Glode said that "divorce is expensive." If he wants to think of CMS and DMS as married, he must know the marriage has been extravagantly expensive already. Component societies are more like sons and daughters with different ways and different needs, but part of the family. Trying to suppress them when they want financial freedom will lead only to alienation and disunity. The British learned that the hard way with our colonists, but it never kept us from helping each other in two wars.

Let's not get all fevered up about what ought to be and can be a benign transition. It still is not clear to me what the leaders in the CMS fear, but they do seem to think that unity and free choice cannot live together. Of course they can, and with a simple scribble of a peaceful pen they will. At the September meeting in Vail, let's leave our six-shooters at the door so we won't hurt each other so badly we'll never heal up.

Thomas H. Coleman, MD

obituaries

Theodore R. Lenz, MD, of the Pueblo Medical Society, died July 21, 1984, in a mountain-climbing accident on Ten Mile Peak near Frisco, Colorado.

Dr. Lenz, 50, practiced general medicine in Pueblo for 21 years. He was a fellow of the American Academy of Family Physicians and a charter diplomate of the American Board of Family Practice.

He received his doctorate of medicine from the University of Colorado Medical Center and did his residency as an Army captain at Fort Leavenworth, Kansas.

He was a member of the Colorado Pathological Society and the Colorado Foundation for Medical Care as well as the Colorado Medical Society. He had also served on the board of trustees at Parkview Episcopal Hospital.

Dr. Lenz was a member of Bethany Lutheran Church.

Survivors include his wife, Betty, three daughters, Kristi Fjare of Illinois, Kathryn Lenz of Illinois and Karmen Lenz of Oregon, and his mother, Erma Lenz of Pueblo.



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Patrick G. Moran, Chairman, Council on Professional Education; David Haggerty, Director, Division of Professional Services

CMS/ERF Launches Medical Student Loan Program

Remember the box in your CMS dues form last year where you could check off a $10 (or more) contribution to the CMS student loan program? Well, many of you did, (approximately 10 percent of the membership) and the fund has now grown to the point where a modest loan program can be initiated.

To administer the funds, the CMS has established a tax-exempt Education and Research Foundation (CMS/ERF), with its own constitution, bylaws, and board of directors (see list at the end of this article). This new arm of CMS will allow us to receive grants and contributions tax free to the donors and to CMS (including interest earned on deposits) and, in time, we will be able to fund a variety of education and research programs deemed worthy of CMS support. Of course, contributions earmarked for the student loan program will be used only for that purpose.

This fall, the CMS/ERF will award its first student loans. Four thousand dollars of the $5000 collected will be available, in increments of $1000. The Directors of the CMS/ERF have set the eligibility criteria upon which the first loan awards will be based. Recipients must be:

1. Senior medical students in good academic standing

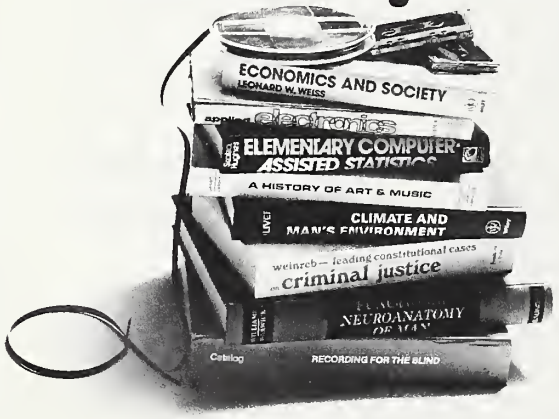
2. Residents of Colorado attending the University of Colorado School of Medicine, or

3. Children of active CMS members, attending any medical school

4. Financially independent from family for three years–if less than three years, family income will be considered in determining financial need.

Besides meeting these criteria, applicants must submit an essay of not more than 500 words on the theme of "Goals and Objectives of Professional Medical Societies." This requirement has been included to encourage early interest and involvement in organized medicine

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among the medical students. The future strength and unity of the medical profession depend greatly upon the success of medical societies to attract members from the younger ranks.

The Medical School and Student Relationships Committee of the CMS Council on Professional Education is now also a committee of the ERF Board of Directors. In that capacity, the committee will read and judge all essays without knowledge of the applicants' identities or financial needs. The student with the winning essay will receive a loan regardless of financial need; other loans will be awarded on the basis of a combination of essay ranking and financial need. Selected essays will appear in future issues of *Colorado Medicine*.

Because of the eligibility criteria, it is anticipated that most loans will be awarded to students at UCSM. The UCSM Financial Aid Office and the Finance Department will assist CMS by handling initial paperwork and by disbursing loan awards and, later, collecting repayments through their established procedures. This will relieve CMS of the burden of these more onerous aspects of the loan program, allowing us to concentrate on fund raising and selection of worthy recipients for our loans.

Speaking of fund raising — you will have another opportunity to contribute to the CMS student loan fund with your next renewal. Remember, you're not limited to just $10. We hope many of you will choose to support this endeavor to help make it the success it deserves to be. Meanwhile, the CMS/ERF is considering other fund raising efforts both for the student loan program and other projects as yet unplanned. Our sincerest thanks to all of you for your past and continued support.

For more information, contact Carl Norberg at CMS (303) 321-8590 x 227.

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book corner

Reviewed by Mark A. Levine, MD

The Medical Industrial Complex

Author: Stanley Wohl, MD

It was but four short years ago that the term "medical industrial complex" was coined by Arnold S. Relman, MD, editor-in-chief of the *New England Journal of Medicine*. That phrase has since become a part of our language as the health care industry has grown even more complex. Corporate interests are an increasingly potent presence in the daily lives of physicians. Medicine is ever more profit-oriented and business-like. Will corporate interests and profiteering replace compassion and caring as the main business of medicine?

Stanley Wohl, MD, has written a concise and readable overview of the business of medicine in his recently-published *The Medical-Industrial Complex* (Harmony Books, New York, 1984). His presentation is not written exclusively for the medical reader, but is neither oversimplified nor condescending. He describes a highly intricate and sophisticated industry in a readable, understandable way without omitting the complicated interactions between the health care industry and government policy. He is sensitive to the labyrinthine interactions within the industry, particularly the ethical dilemma of entrepreneurs as simultaneous providers and suppliers of medical services.

Dr. Wohl presents his observations from the perspective of a physician and an academician. He is obviously concerned about this threat to the traditional health care system. He suggests that we can evolve a health care system responsive to the fiscal and medical needs of the country only through a partnership of industry, government and academia working together and respecting the strengths and weaknesses of each other.

But there are other influences upon the future of American health care. Business itself is proving to be an important force. After all, business is the major purchaser of health care in America. Thus, business will help to decide the type of product that will be purchased. Business itself will help to prevent the corporate abuse of American health care.

Medical practice, however, must remain the final arbiter in the public's interest. The profiteers and the regulators may jockey all they wish, but they cannot determine the effectiveness or usefulness of medical practice. For instance, both industry and government had their opinions of CT scanning, but it is the practice of medicine which is determining its ultimate utility. Medical practice is where the influence of profit and the constraint of regulation become manifest in the health care industry, and it is through medical practice that the public will balance these forces to determine its own best interest.

The Medical Industrial Complex provides a stimulating and thought-provoking perspective on the profit motive in health care, and is a welcome overview of this important aspect of modern medical practice.

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Fat Consumption Linked to Cancer

Research on animals treated with carginogens suggests that in a low-fat diet, the risk associated with unsaturated fat may be higher than the risk associated with saturated fat, according to David Kritchevsky, Ph.D., of the American Institute for Cancer Research (AICR).

At an AICR interview, Dr. Kritchevsky and another researcher, T. Colin Campbell, Ph.D., said that these research findings may present a dilemma to consumers who have switched to unsaturated fats to reduce the risk of developing heart disease. Total fat reduction in the diet is the optimal way of decreasing the risk of developing either heart disease or cancer from dietary fat, Dr. Campbell said.

Cancers of the breast, colon and prostate are particularly linked to high fat consumption, although both scientists caution that nutrition is only one factor affecting cancer incidence, and that more studies of nutrients are needed before research in this area can be considered conclusive.

AICR's dietary guidelines to lower cancer risk, based on recommendations from the National Academy of Sciences Committee on Diet, Nutrition and Cancer are:

- Reduce the intake of dietary fat, both saturated and unsaturated, from the current average of approximately 40 percent to a level of 30 percent of total calories.
- Increase the consumption of fruits, vegetables and whole grain cereals.
- Consume salt-cured, smoked and charcoal-broiled foods only in moderation.
- Drink alcoholic beverages only in moderation.

Dr. Campbell is Professor of Nutritional Biochemistry at Cornell University and is Senior Science Advisor to AICR. Dr. Kritchevsky, of the Wistar Institute, is a member of AICR's grant review panel.

First Research Symposium on the Late Effects of Polio Held

The 300,000 Americans who contracted and survived polio during the epidemics of the 1940s and '50s should be concerned, but not frightened, and get medical help if they suffer increased muscle problems of weakness, fatigue and pain.

This is the message that came out of the National Symposium on the Late Effects of Poliomyelitis, held this summer at the Roosevelt Warm Springs Institute for Rehabilitation. Forty researchers and physicians, some of whom are polio survivors, from the U.S., Canada, England, Denmark, Mexico and Sweden, met at the institute (originally the Georgia Warm Springs Foundation, established by Franklin D. Roosevelt for the aftercare of polio victims.)

The physicians at the symposium agreed that as many as one out of four "post-polios" may experience progressive weakness, new fatigue and muscle pain. The participants agreed to share basic research and clinical experiences to determine the extent of such problems, to develop an evaluation and protocol procedure and to increase public and physician awareness of the problems of post-polio patients.

Symposium participants recommended that post-polios who are becoming weaker should exercise only under their physician's supervision, should stay within a normal weight range, get adequate rest and nutrition and deal with stress positively.

Possible causes for these health and neurological changes which were discussed by the participants included premature aging of nerve cells damaged by the earlier infection with polio; reactivation of the polio virus, an immune response triggered by an unknown event; and a diminished ability with aging for polio-afflicted muscles to continue functioning normally.

A number of post-poliomyelitis support groups have been established. Information on establishing such a group may be obtained from Mrs. Dianna Oglesbee, who has formed one in Ohio. Her address is 1063 Tabor Ave., Kettering Ohio, 45420; (513) 254-7917.

Symposium proceedings will be published within the next few months. For information on the symposium, contact the Roosevelt Warm Springs Institute for Rehabilitation, PO Box 1000, Warm Springs, Georgia, 31830 or call (404) 655-3321, extension 3363.

The Western Post-Polio Conference 1984 will be held in Oakland, California, December 1 and 2, 1984. Physicians, physical and occupational therapists, and researchers will address the issues of the long-term effects of polio, degenerative arthritis, osteoporosis, scoliosis, respiratory complications and late progressive weakness.

Featured speakers will be Augusta Alba, MD, specialist in respiratory complications of Polio at Goldwater Memorial Hospital on Roosevelt Island in New York and Adolph Ratzka, Ph.D., research in post-polio ventilation equipment in Stockholm, Sweden. Stanley Yarnell, MD, specialist in rehabilitation medicine and post-polio, is medical director of the conference.

For further information contact Renah Shnaider, 350 Vernon #101, Oakland, California 94610. (415) 832-2574.

Dr. Arenberg Awarded International Honor

I. Kaufman Arenberg, a Denver ear specialist, recently received the International Pietro Caliceti Gold Medal for his research on Meniere's Disease. The award is given once every four years for major contributions in hearing and balance research. Dr. Arenberg was honored for his work, "The Surgical Anatomy of the Endolymphatic Sac," published in 1977 in the *AMA Archives of Otolaryngology*.

In his research, Dr. Arenberg and biomedical engineer John B. Newkirk invented a small valve which has been highly successful in relieving the symptoms of Meniere's Disease. The tiny plastic valve is inserted through the bony area behind the external ear and into the inner ear where it drains excess fluids.



I. Kaufman Arenberg, M.D.

Meniere's Disease is one of the more common inner ear disorders which afflects between 2.4 and 7 million American adults and children. Those with the disease experience attacks of vertigo, fluctuating hearing loss, tinnitus and ear pressure or fullness of the ear. The attacks of vertigo may occur suddenly and without warning. Violent spinning, whirling and falling feelings associated with nausea and vomiting are common symptoms.

Dr. Arenberg is the director of the International Meniere's Disease Research Institute at the Colorado Otologic Research Center and Children's Deafness Foundation at Porter Memorial Hospital/Swedish Medical Center.

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The Evolution of COPIC

by K. Mason Howard, MD

***Editor's Note:** K. Mason Howard is the Chairman of the Board and Chief Executive Officer of COPIC Trust. Dr. Howard has been active in the professional liability arena for a number of years, beginning in 1971 with the CMS professional liability program with Hartford. He served on the CMS professional liablity review committee, and has been president of the Colorado Medical Society, Colorado Foundation for Medical Care and the Arapahoe Medical Society. Dr. Howard practices orthopedic surgery in Littleton and is Medical Staff Officer at Swedish/ Porter Hospitals.*

When COPIC Insurance Company becomes a reality, it will further assure long-term stability as a physician-owned liability carrier providing the best insurance products for Colorado physicians. As COPIC begins a new era, it seems worthwhile to review the history of COPIC and how we arrived at this solid position.

COPIC Trust started in late June, 1981 providing a deductible claim reimbursement coverage as an adjunct to the CMS-sponsored Hartford Fire Insurance Professional Liability program. The brokerage firm for this program was Warren & Sommer. It was then intended that this modest funding role would be played by COPIC for a three-to five-year period. COPIC wanted to have more financial and management control over its sponsored program, in partnership with Hartford, and gradually increase its share of responsibility in the program. At that time, the CMS Board did not want to move into the insurance business in competition with Hartford. The board did not feel that there would be sufficient support for a $1,000 to $2,000 per physician investment needed to create a minimum capital fund of $3 million to incorporate a Colorado insurance company. During the first year of this partnership with Hartford, the COPIC Trust accumulated about $3.5 million of assets. COPIC, seeking to set up a captive insurance company as a contingency plan or as a replacement to the COPIC Trust, held discussions with Commissioner Barnes of the Colorado Insurance Division. The commissioner rejected these requests because COPIC could not demonstrate that adequate malpractice coverage was not already available.



CMS staff provided COPIC with support services through most of this period. COPIC intended from the beginning to hire insurance professionals to handle underwriting and claims. However, its primary mission was to benefit CMS members and to receive ongoing administrative support from CMS.

On March 17, 1982, Warren & Sommer and Hartford gave CMS and COPIC an ultimatum — either to accept a 23 percent Hartford rate in-

(Continued on p. 237.)

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Meeting the Challenge of a Changing Malpractice Climate

***Editorial Note:** Larry W. Thrower is President of COPIC Insurance Company. Mr. Thrower is a well-known and respected consultant in the medical malpractice field. He has served as broker/consultant to the University of Colorado Health Sciences Center for 17 years and as a member of the UCHSC's trust advisory board for five years. His insurance career spans a quarter of a century, during which time he has been associated with INA, Garrett-Bromfield Insurance, Inc. and Walsh, Moore, Garrett-Bromfield, Inc., a subsidiary of Tomenson, Saunders Whitehead, Ltd., which he served as chief executive officer. Mr. Thrower was elected to the COPIC Trust Board in March, 1983. In addition, he teaches insurance classes and consults for various public and private entities in the medical/insurance fields.*

During the 1970s, the insurance industry experienced crises in several major casualty lines of insurance. Professional liability insurance was one product that suffered extreme adversity caused by high dollar awards and an increased number of patient suits against physicians. Many insurance companies realized that the underlying structure of the risks they were underwriting had been radically altered.

Since the insurance companies that had been underwriting professional liability risk were in business to make a profit, they had two alternatives available to them — to leave the market entirely or to dramatically increase premimum rates. Many insurance companies withdrew from the marketplace, concluding that losses were far too unpredictable to effectively manage. The remaining insurers recognized that the withdrawal of others from the marketplace represented an opportunity to gain a larger market share, and increased their premiums to ensure that they would survive an onslaught of claims. For the physicians this meant sharply increased premiums for similar or lesser coverage, or a search for another carrier.

The point here is that the nature of professional liability insurance has indeed changed. Insurance companies are not inherently evil nor do they make decisions arbitrarily; they simply want to provide a product and price it so they can continue to do business. However, particularly for the physician with an excellent loss record, it is difficult to grasp the rationale behind dramatic price increases.

Individual physicians cannot afford to insure themselves since professional liability losses occur far too infrequently and at such great cost. Physicians require continuously available coverage from an insurer at stable rates. They do not want to search for a new carrier each year,

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nor have reasonable rates only when the financial market allows the insurance company a kindly return on investments, nor experience exorbitant rate increases when claims are filed.

The concept of insurance is predicated upon the statistical reliability of loss forecasts which can only be achieved when a large number of individuals are covered by one entity. In 1981, the Colorado Medical Society recognized that it had become the responsibility of the physician himself to acquire coverage against potential losses at the best possible price. The Colorado Medical Society concluded that, through its sponsorship, a large group of physicians could assume their own risk and achieve two major goals: to have professional liability insurance continually available and to stabilize rates.

It is important for Colorado physicians to realize that the self-assumption of risk does not mean a moratorium on premium increases. On the contrary, the self-assumption of risk requires conservatism much as retirement planning does. Any physician who expects to save more than the profit margin the insurance company would have otherwise earned does not truly grasp the nature of the situation. COPIC Trust's financial and underwriting goals were set to assure that the company would not only survive the initial years, but would also remain financially sound. COPIC assumes only the first $100,000 of loss for each physician, with $300,000 aggregate limits, while transferring the remaining risk to reinsurers. This means that COPIC has retained the statistically predictable portion of losses and insured itself against catastrophic occurrences. Investment income earned on premium dollars has been retained to provide a buffer against adverse losses and to ensure the program's success in the future.

COPIC's orientation is long-term. Physicians hoping to gain swift and significant premium savings will not be immediately satisfied. The COPIC program requires an enduring commitment by the individual physician to match COPIC's commitment to be a constant provider of professional liability insurance. Physicians who have practiced in Colorado for a number of years can cite the names of insurance companies that have come and gone. Since COPIC has been formed by the Colorado Medical Society for the benefit of physicians practicing in the state, we will not retreat from this marketplace. Currently, other insurance companies are dramatically increasing their premium rates, in some instances, more than 30 percent. Unlike these other companies, we don't believe that the physician can't remember what he paid in premiums last year. COPIC views professional liability insurance premiums as a cost that can be controlled.

More than 2200 physicians who have been insured with COPIC since 1981 have received excellent service. These physicians who helped found the program and make it successful are willing to offer the same advantages to others who join before October 1, 1984. Currently, COPIC is engaged in a membership drive to gain as many physicians as possible before that date. This does not mean that we won't insure you after October 1, when you realize that COPIC offers you the best program; it only means that you won't be able to participate in certain significant long-term benefits.

COPIC has established two premium credit plans open to physicians who are insured by October 1, 1984:

The Preferred Risk Premium Plan (PRPP), recognizes the physician who has incorporated sound risk management techniques into his daily practice, and has an excellent loss record over a prolonged period of participation in a CMS-sponsored professional liability program. Initially, this premium credit reduces the physician's premium by 10 percent of the $100,000/$300,000 level. In the future, COPIC Trust and COPIC Insurance Company will expand PRPP physician eligibility and the second-year premium credit will be increased to 15 percent. The plan's goal is to motivate all insured physicians to concentrate on minimizing their exposure to risk. Many physicians do not pay enough attention to these matters until it is too late. COPIC takes a preventive stance.

A deductible program, to be introduced in 1985, will reward participating Colorado physicians who renew their policies and maintain a long-term commitment to the program. This program has been made possible because of the investment income COPIC has earned on premiums collected. The immediate

(Continued on p. 237.)

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.....assure quality continuing medical education for you.

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The COPIC Difference: Security, Stability and Service

Editor's Note: Stephen M. Cohen is Vice President of Insurance Operations for COPIC Insurance Company. He brings to COPIC more than eight years technical insurance expertise with Marsh & McLennan Companies. Mr. Cohen specialized in actuarial and insurance consulting primarily for healthcare institutions and since 1981 has been involved in all phases — actuarial analysis, planning, coordinating and implementation — of the COPIC professional liability program.

COPIC'S ongoing philosophy can be simply stated:

- Responsible Management
- Proven Performance
- Fiscal Stability
- Professional Services

Effective management has been the key to COPIC's growth and success. COPIC's management approach involves a unique blend of physician medical expertise with the diverse skills of many other professionals whose knowledge is vital to the functioning of a complex insurance operation. Consistent with our objective of providing a service-oriented, cost-stable insurance alternative to Colorado physicians, all significant decisions are made with thorough analysis and review by the COPIC Board and working committee members. The physician-oriented governing body is supported by a staff of professionals with many years' experience in such disciplines as insurance company management, administrative services, claims handling, marketing, finance and accounting.

In addition to the internal functions, COPIC retains supporting professional services to provide expertise in risk management, legal services, actuarial services, reinsurance, investment and computer operations. The individuals who provide these services to COPIC are the foremost in their fields. Their assistance and advice is critical to COPIC's success. This strong sense of dedication and responsibility by everyone involved will maintain COPIC's management effectiveness. COPIC is committed to the development of a stable, financially sound program which is responsive to a changing society.

Effective management has been the key to COPIC's growth and success.

COPIC's ultimate responsibility to its clients is to provide prudent management of premium dollars, assuring long-term stability and insurance availability. By constantly maintaining expense control (a 15 percent ratio of administrative expense to the written premium), the physician's premium dollar is used for what it was intended — the defense and payment of claims. As the financial results clearly indicate, COPIC's performance has been excellent. Erroll Hossack, Financial

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Vice President of COPIC, reports the following balance sheet and income statement figures as of June 30, 1984:

- Total assets of $16,544,000 representing cumulative investments, surplus contributions, and other assets.
- Total surplus of $3,874,000 which includes assets held over and above amounts estimated to be necessary to pay all claims and liabilities.
- Cumulative investment income of $2,419,000.

Premiums are invested in high-yield bonds. The investment income contributes to COPIC's surplus. Reviewing the entire COPIC bond portfolio, Mr. Hossack reports average yields of: 10 percent on tax-free municipals, 13 percent on government bonds, and 14 percent on corporate securities. COPIC's total bond portfolio has an average rate of return of 12.7 percent. Additionally, all bonds are high quality, largely insulating COPIC from adverse market conditions. The successful investment program enhances the company's capability to guard against unanticipated claims activity.

The new COPIC Insurance Agency is qualified to write all types of coverage.

COPIC's claims department, headed by Bo Fry and Tom Witham, investigates all incident reports, establishes claim reserves and monitors all claim activity. This department ensures adherence to COPIC'S strict philosophy on claims — to settle all worthwhile claims as quickly and equitably as possible, and to defend the physician against all unmerited claims. Continued, vigorous reaction to frivolous suits is essential. No claims are settled without the consent of the insured physician.

The purpose of COPIC'S risk management program is to improve the quality of medical care and to reduce the incidence of malpractice allegations. The risk management department is headed by Robert S. Brittain, MD, a former surgeon who, since 1975, has worked full time in the field of physician risk management. George Thomasson, MD, a family practitioner, is also a full time risk manager with COPIC. COPIC, increasingly aware of the trend toward more severe losses, has intensified its loss prevention efforts. Such efforts are largely educational, such as articles, seminars and lectures. Claims data and individual files are analyzed regularly for evidence of recurring and preventable problems. The risk management department works very closely with the claims department. When identified, a problem is studied and solutions proposed.

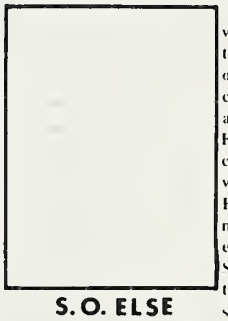
COPIC's main objective is to insure as many Colorado physicians as possible who incorporate sound risk management techniques in their daily practices. The job of risk manager is to assist in reducing to a minimum the physician's risk of being sued, losing a suit, or spending more funds than absolutely necessary in the event of a loss. Your actions have the greatest impact on the quality of patient care and on future premiums. The COPIC risk managers are available at 321-3884. You should call them if you have risk management questions; if you have a medical liability suit against you, but would prefer to discuss it first with a physician (in most such cases you would call the claims department); if you would like a risk manager to talk to your medical staff, component society or specialty society; or any time you have an incident which involves a substantial treatment or surgery complication, a diagnosis failure or persistently angry patient's family. In such circumstances, do not wait for attorney involvement!

The policyholder services department, managed by Mary Celi, is the hub of COPIC. It is the initial contact with each physician and is dedicated to provide prompt, personal service to all policyholders. Once you make a request for a premium quote or other information, you are tracked through COPIC's internal files to ensure the prompt, professional and personal attention that you deserve. COPIC's toll-free number (1-800-421-1834) makes it easier for you to contact us, and we hope that you will use it.

To provide a centralized service area for all your insurance needs, our new full-service COPIC Insurance Agency is qualified to write all types of insurance coverage. This new agency will provide physicians an easy access to various insurance products and act as your advocate and personal insurance counselor. Pat Schultz and Barbara Westerman will assist you in packaging an insurance program that is appropriate for your individual practice and lifestyle.

We are available to answer all your questions and provide you with prompt service when you call 321-8590, in Denver, or 1-800-421-1834 outside the metro area.

CMS MOURNS LOSS OF LONG-TIME MEMBER



S.O. ELSE

The Medical Society was saddened to learn this week of the death of one or our medical community's most valuable members, Someone Else. Someone's passing creates a vacancy that will be difficult to fill. Else has been with us for many years and for every one of those years, Someone did far more than a normal person's share of the work. Whenever leadership was mentioned, this wonderful person was looked to for inspiration as well as results: "Someone Else can work with that group." Whenever there was a job to do, a resident to teach, a meeting to attend, one name was on everyone's lists — "Let Someone Else do it." It was common knowledge that Someone Else was always the one who was happy to see the unfortunate patient with no income or insurance. Whenever the society was called upon to support a charitable or community project, everyone just assumed that Someone Else would provide what was needed. Someone Else was a wonderful person — sometimes appearing superhuman, but a person can only do so much. Were the truth known, everybody expected too much of Someone Else. Now Someone Else is gone! We wonder what we are going to do? Someone Else left a wonderful example to follow, but WHO is going to follow it? Who is going to do the things Someone Else did? When you have a chance to participate in the society activities REMEMBER — we can't depend on Someone Else anymore.

Now that Someone Else is no longer available . . .

perhaps *you* would like to become involved in the activities of your County Medical Society. You can make the decision right now to participate *actively*, not just pay dues and have no say.

1984 CMS/CMSA Annual Meeting
September 20-22, 1984
Marriott Mark – Vail, Colorado
(1-476-4444)

Wednesday, September 19

9:30 am - 1:00 pm	Medical Executives Group
11:30 am - 1:00 pm	CMS Finance Committee
1:00 pm	CMS Board of Directors
1:00 pm - 5:00 pm	CMS Hospital Medical Staff Section
4:00 pm - 6:30 pm	Registration
6:30 pm	Welcome Reception Hosted by Marriott Mark

Thursday, September 20

7:00 am	Registration
7:00 am	Prayer Breakfast (M. Roy Schwartz, MD, "Medicine & The Bible")
7:00 am	Constitution, Bylaws and Credentials Committee
8:00 am - 5:00 pm	CMSA Hospitality Area
8:00 am - Noon	House of Delegates (CFMC Corporate Meeting)
9:30 am - 4:30 pm	Country Store - CMSA
10:00 am - 12:30 pm	CMSA House Tour
Noon	Reference Committee Chairmen Luncheon
Noon	CMS Past President's Luncheon (By Invitation Only)
1:30 pm	Reference Committee Hearings
2:30 pm - 4:00 pm	CMSA County Presidents/ President-elects
4:00 pm	Exhibits Open
4:30 pm - 6:30 pm	Exhibitors Reception in Exhibit Area
6:00 pm - 7:30 pm	CMSA Reception - Honoring AMAA President-elect, Mary Kay McPhee
7:00 pm	Specialty President's Dinner Meeting (By Invitation Only)

Friday, September 21

7:00 am	Registration
8:00 am - 4:30 pm	Exhibits
8:00 am - 5:30 pm	CMSA Hospitality Area
9:30 am - 4:30 pm	Country Store - CMSA
8:30 am - 3:30 pm	Scientific Program - "Changing the Face of Medical Practice"
8:30 am - 9:30 am	Health Care Services - The Evolving Competitive Marketplace
9:30 am - 10:30 am	Consumers' Views of Medical Care and Medical Costs • Hospitals • Business and Industry • Medical Insurance Carriers
10:30 am - 11:00 am	BREAK (exhibit area)
11:00 am - noon	Panel continues
11:45 am - 1:00 pm	COMPAC Luncheon
1:30 pm - 2:30 pm	The Role of the Medical Profession in the Emerging Integrated Health Care Organization
2:30 pm - 3:30 pm	Impact of the Future on Medical Practice Sponsored by CMSA
6:30 pm	Presidents' Reception
8:00 pm	Presidents' Dinner

Saturday, September 22

8:00 am - 3:00 pm	CMSA Hospitality Area
8:00 am	Registration
8:00 am - Noon	Exhibits
8:30 am	CMSA Open Board Meeting
8:30 am - 11:00 am	Scientific Program - Workshops (Three Concurrent Sessions) • DRGs and the Hospital • The Ethical Implications of Rationing and Cost Containment - Impact on Medical Practice • Recent Scientific Investigations of the Shroud of Turin (John Jackson, Ph.D., Vice-President, Shroud of Turin Research Project)
9:00 am - 2:00 pm	Country Store - CMSA
10:00 am	CMSA General Membership Meeting (Installation of Officers)
Noon	CMSA Annual Luncheon
1:30 pm	House of Delegates
2:00 pm	CMSA Incoming Board of Directors Meeting
Immediately Following Adjournment of House	CMS Board of Directors Reorganizational Meeting

Continuing Medical Education

CALENDAR

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September, 1984

6-7 **Advanced Trauma Life Support** — Orr Major Hall, University of Kansas Medical Center, Kansas City, Kansas. Credit: 16 hrs. AMA Cat. I; 15 hrs. AAFP; 15 hrs. AOA 2-D. Fee: $350. Maximum attendance: 16. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th & Rainbow, Kansas City, KS 66103. (913) 588-6124.

6-7 **A Special Workshop on the Use of the CO2 Laser in ENT Surgery** — Sudler Hall, University of Kansas Medical Center, Kansas City, Kansas. Credit: 16 hrs. AMA Category I; 15 hrs. AAFP. Fee: $600. Maximum attendance: 9. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

6-9 **Physics of Diagnostic Radiology** — University of California, Davis Campus, Davis, California. Credit: 25 hours AMA/CMA Category I. Tuition: $250. Contact: Office of Continuing Medical Education, School of Medicine, TB 150, Univ. of Calif., Davis, CA 95616. Jane A. Johnson, Publications Representative (916) 752-0328.

7-8 **The C. Richard Hawes Pediatric Cardiac Pathology Conference** — Steamboat Springs, Colorado. Designated for primary care physicians and specialists. Subjects covered: cardiovascular disease - pediatrics. 8 hrs. instruction. Contact Pamela C. Madden, Conference Planner (303) 861-6949. Sponsored by The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218.

9-14 **Hilton Head General Medicine Conference** — Mariner's Inn, Hilton Head Island, South Carolina. Fees: $335 for physicians, $225 for nurses, residents and allied health professionals. Contact: Conference and Institute Program, PO Box 11338, Denver, CO 80211 (303) 629-5333.

10-11 **Challenges for Clinical Nutrition in the 80s** — Marriott Pavilion Hotel, St. Louis, Missouri. Contact: Donna M. Baudrau, Meeting Manager, American Society for Parenteral & Enteral Nutrition, 1025 Vermont Ave., N.W., Suite 810, Washington, D.C. 20005. (202) 638-5881.

10-15 **Family Practice Review** — University of Colorado School of Medicine, Denver, Colorado. Credit: 40 hrs. Category I AMA; 40 prescribed AAFP; 40 hrs. Category 2-D AOA. Contact: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. 9th Ave., Box C-295, Denver, CO 80262. (303) 394-5241.

11-12 **Conference on Homeostatic Functions in the Elderly** — Sheraton St. Louis Hotel, St. Louis, Missouri. Contact: Sharon Smith, Conference Secretary, GRECC (111G-JB), V.A. Medical Center, St. Louis, MO 63125. (314) 894-4659.

14 **Basic & Clinical Electroretinography (ERG), Electrooculography (EOG), & Visual Evoked Response Recording** — University of Kansas Medical Center, Kansas City, Kansas. Fee: $140. Credit: 7 hrs. AMA Category I. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

15-20 **Hilton Head General Surgery Conference** — Mariner's Inn, Hilton Head Island, South Carolina. Fees: $335 for physicians, $225 for nurses, residents & allied health professionals. Contact: Conference & Institute Program, PO Box 11338, Denver, CO 80211. (303) 629-5333.

20-21 **Practical Therapeutics: 1984** — A Western Regional Symposium — Regency Hotel, Denver, Colorado. For: pharmacists, doctors, nurses and other health professionals. Credit: 1.2 Contact: Becky Fisher, Rocky Mountain Drug Consultation Center, 645 Bannock, Denver, CO 80204-4507. (303) 893-3784.

21 **Progress In Oncology — Early Diagnosis and Alternatives in the Treatment of Early Breast Cancer** — Pueblo, Colorado. Sponsored by Southern Colorado Clinic, St. Mary-Corwin Hospital. Credit: 1.0 hours. Featured speakers: Jay Harris, MD; Mark Weinstein, MD. Contact: St. Mary-Corwin Hospital, Department of Education and Training, 1008 Minnequa Ave., Pueblo, CO 81004. (303) 560-5343.

21-22 **Treatment of Difficult Adolescents** — Denver Hilton, Denver, Colorado. Speakers: Charles A. Malone, MD; Frank S. Williams, MD; John Conger, MD. CME Credits: 9 hrs. Contact: Sylvia Bowen, Colorado Child & Adolescent Psychiatric Society, 8674 W. Rice, Littleton, CO 80123. (303) 979-6310.

23-27 **Hospital Medical Staff Conferences & Hospital Trustee Forum** — YMCA Conference Center, Estes Park, Colorado. Contact: Estes Park Institute, PO Box 400, Englewood, CO 80151. (303) 761-7709.

24-25 **Current Trends in Childhood Diabetes** — Denver, Colorado. Tuition: $75. Approved for 13.5 continuing education hours for physicians, RNs and dieticians. Contact: Virginia Carey, RN, Barbara Davis Center for Childhood Diabetes, 4200 E. 9th Ave., Box B140, Denver, CO 80262.

25-28 **Joint Conference on Occupational Health** — Hotel Utah, Salt Lake City, Utah. Contact: Joint Conference on Occupational Health, 2340 S. Arlington Heights Rd., Arlington Heights, IL 60005.

27-28 **Rehabilitation & Continuing Care in Cancer** — Doubletree Hotel, Overland Park, KS. Credit: AMA, AAFP, CNE, SW. Fee: TBA. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd, Kansas City, KS 66105.

28-29 **13th Annual Montrose Fall Clinics** — Montrose, Colorado. Credit: 10 CME hours. Contact: Kathy Holman, Montrose Memorial Hospital, 800 S. 3rd St., Montrose, CO 81401. (303) 249-2211, Ext. 243.

Evolution

(Continued from p. 229.)

crease and a continuation of the current program, or to terminate the Hartford/Warren & Sommer relationship with CMS.

In a tremendous flurry of activity between March 17 and June 30, 1982, the COPIC Board, together with its insurance consultant, legal counsel, CMS staff, and policyholder services took on the Herculean task of establishing a full-fledged insurance operation. Arranging reinsurance coverage, creating systems for underwriting, policy issuance, billing and bookkeeping were all required to implement COPIC operations. COPIC contracted with MLCP (Dr. Robert Brittain's firm) for risk management services, with Johnson, Mahoney & Scott as our lead defense counsel and obtained reinsurance from North American Reinsurance Company, which agreed to fully back the COPIC Trust operation. On June 30, 1982, COPIC went into business as a trust, providing professional liability insurance coverage for more than 2,000 physicians.

Since 1982, COPIC Trust has collected more than $4 million in surplus assets, in excess of anticipated losses. Now that we have achieved this surplus, COPIC is in the process of becoming licensed by the state of Colorado to provide coverage as a fully-admitted insurance company. COPIC seeks this licensure to demonstrate compliance with insurance regulatory requirements, and to qualify the company for protections of the insolvency provisions of Colorado insurance law.

COPIC has indeed made huge strides since the spring of 1982. We are soundly organized, professionally staffed, and fiscally sound, thus assuring Colorado physicians that we will be here over the long haul. The vagaries of the insurance market will have minimal effect upon the physician-owned company's policies and prices. COPIC will remain the most durable name in Colorado professional liability coverage, as profit-seeking competitors come and go throughout the years.

Changing Climate

(Continued from p. 232.)

economic benefit of this program is a premium credit of 5 percent of the $100,000/$300,000 premium level.

COPIC offers the Colorado physician a means to control a significant portion of his insurance expense. Until now we have exclusively concentrated on professional liability insurance. Through the new COPIC Insurance Agency, we can now offer Colorado physicians the same benefits for their business and personal insurance needs. The Colorado physician will now have one source for all his insurance needs.

COPIC was originally formed to meet the long-term needs of the physician for professional liability insurance. We have established a sound financial and operational base. We strongly urge those of you who are not insured with us to give us your very serious consideration.



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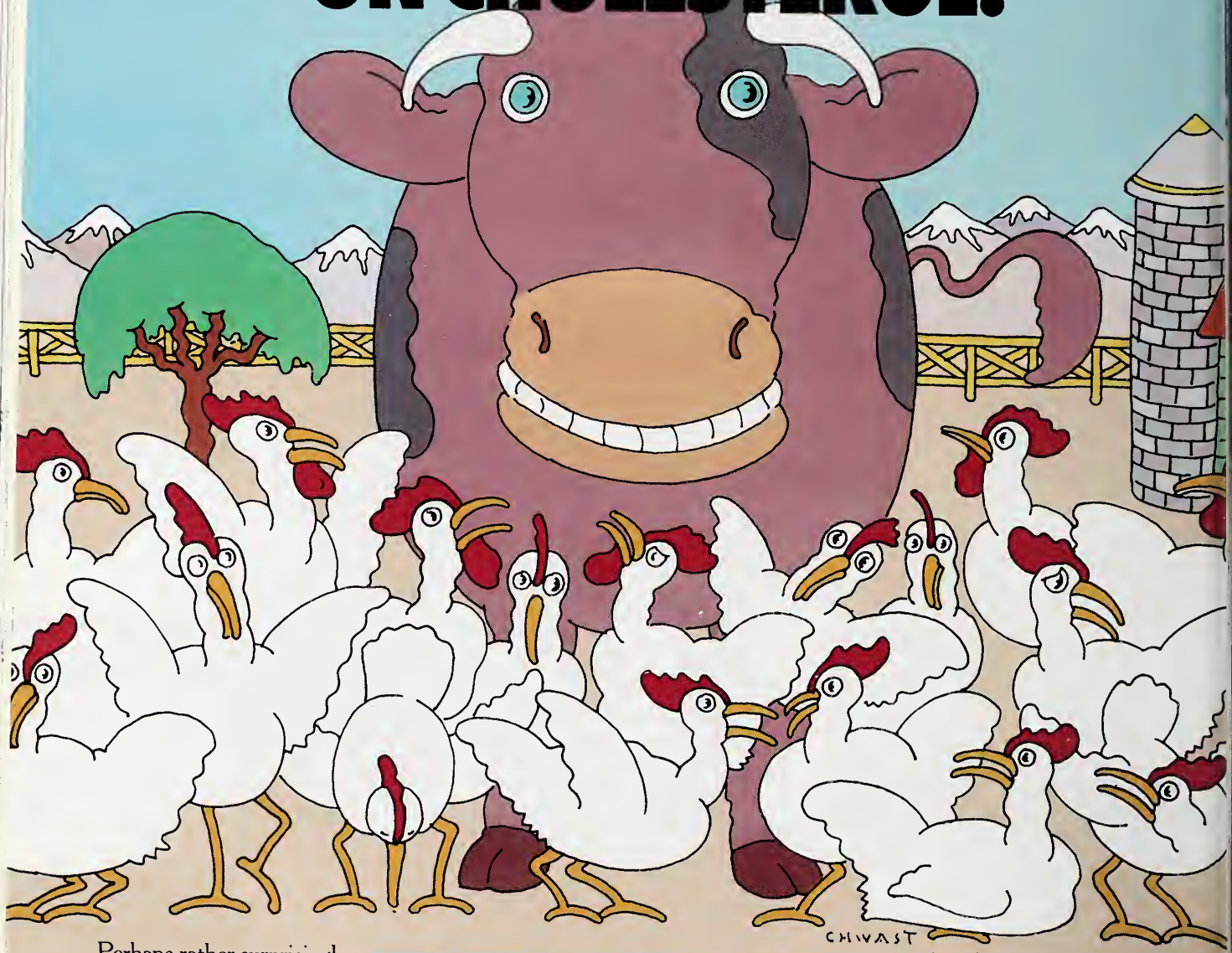
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ANNOUNCING SOME NEW FINDINGS ON CHOLESTEROL.



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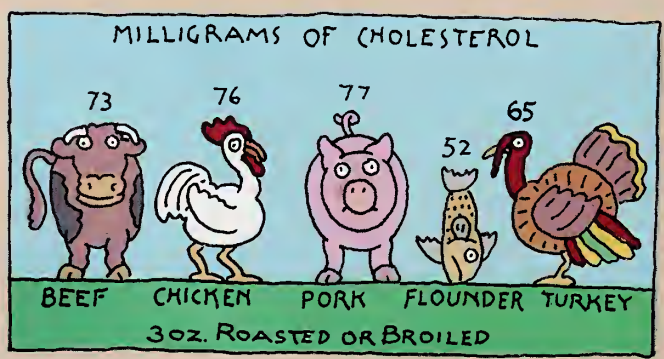
That was the finding of a new U.S.D.A. study on beef nutrient composition.*

That same study found beef is lower in calories than ever.

And lower in fat.

In fact, three ounces of beef now has just 192 calories and a modest nine grams of fat, over half of which is unsaturated.

Today, new breeding and feeding techniques are making beef a whole different animal. Though not so different that it isn't still one of the body's bes sources of iron, zinc, B-vitamins and protein.



It all means moderate portions of beef can fit easily int a reduced cholesterol, low saturated fat diet.

And that can stop a lot of squawking when you recommend one.

For a free reprint of this ad or additional information on the new U.S.D.A. beef study, write to: Department of Research and Nutrition Information National Live Stock and Meat Board, 444 North Michigan Avenue, Chicago, Illinois 60611.

*Beef data from 1983 Beef Nutritive Composition Studies conducted by the U.S.D.A. and National Live Stock and Meat Board.

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This Month's Cover features incoming CMS President W. Gerald Rainer, MD. Dr. Rainer's first President's Letter, on p. 145, discusses the major issues facing the medical society in the coming year. Dr. Rainer's column also includes a letter written several years ago to his son, who was in medical school in Dublin. This letter, according to Dr. Rainer, embodies his thoughts and beliefs about the principles of medicine.

Also this month, CMS attorneys Lawrence M. Wood and Constance B. Wood discuss a successful lawsuit against the Chiropractic Association in which CMS took part. This case has important implications for Colorado physicians and the health and safety of Colorado high school athletes. The article, Victory in Brighton County Court, begins on p. 157.

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president's letter



W. Gerald Rainer, MD
President, Colorado Medical Society

The Best of Times and The Worst of Times

Editor's Note: The following remarks are excerpted from Dr. Rainer's inaugural speech at the 1984 CMS Annual Meeting in Vail.

It was the best of Times;
it was the worst of Times.
It was the age of Wisdom;
it was the age of Foolishness.
It was the epoch of Belief;
it was the epoch of Incredulity.
It was the season of Light;
it was the season of Darkness.
It was the spring of Hope;
it was the winter of Despair.

So wrote Charles Dickens in 1858 as the opening line to *A Tale of Two Cities*, and he was not even president-elect of any component medical society. However, he did have the vision and depth of perspective to see beyond the problems of the day and, perhaps, to predict the current status of our medical society. Lest we lose faith, recall the final words of the book's hero, Sidney Carton, as he walked to the gallows—

It is a far better thing that I do,
than I have ever done.
It is a far better place to which I go,
than I have ever been.

After what seems to be years of struggling with problems of financial woes, frustrating building ventures, conflict from without and within, it is time for us to turn our energies and our combined talents toward more important and more pressing issues.

Currently, we have exhausted our financial reserves and face a serious crisis in the maintenance of adequate members to carry out programs to attain meaningful goals. A detailed breakdown of the CMS financial position will be available shortly to any member who wishes it.

We are in the process of conducting a long overdue strengthening of our staff organization. We are in the process of searching for a new executive director and will be most cautious in the selection of someone who is most qualified for this very

When purchasing an office computer system . . .

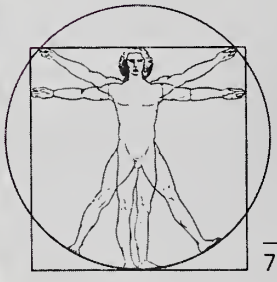
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key position.

The state society, along with some component societies, is experiencing a potentially serious problem in the recruitment of new members. We must not let Freedom of Choice and similar issues continue to be divisive but must find some solution mutually acceptable and helpful to all societies. I believe we can do this by making our CMS programs, projects and activities more desirable, more meaningful and more helpful to our members.

Implementation of these programs will require continued support and work by many dedicated physicians who have already given enormous time and energies to the society. In addition, we need and earnestly solicit the involvement and input from new young members—from medical students and those new to the practice of medicine in the state of Colorado. Therein lies our future.

I consider it an honor to be your President—a responsibility to be your leader—a pleasure to be your colleague—and a privilege to be your servant. Our path of recovery certainly is going to require continued devotion and effort for the next three to five years. I sincerely hope that our report next year will be a more optimistic one.

Although I wrote the following letter to my son in medical school in Dublin some five years ago, this still embodies my philosophy and belief in the principles of medicine. I am pleased to share these thoughts with you.

Though I am old with wandering
Through hollow lands and hilly lands
I will find out where she has gone
And kiss her lips and take her hands,
And walk among long dappled grass
And pluck till time and times are done
The silver apples of the moon
The golden apples of the sun.

William Butler Yeats, ***The Song of the Wandering Aengus,*** *Stanza 8*

Dear Bill

Now that you have finished your first year at the Royal College of Surgeons Medical School in Dublin, I hope you won't mind if I use this opportunity to communicate with you and the membership of the medical society conjointly. I wanted to write to you directly, and I also need to share my philosophy as a final President's Message to the Denver Medical Society terminating my year in office.

I have reflected over your early years in Denver and compared them with those of my generation. Things were so much easier for us during high school, college and beyond. There was no question about the course to follow for most of us, and (we thought) no options. High school—college—graduate school for a professional career. That was expected. No questions asked. Not so for you and others like you. Yours and your contemporary generations have made all mankind aware of other facets of society that are meaningful. Turbulent times, those, in and following the great social revolution of the 60s and early 70s—civil rights, Viet Nam, increased awareness of people and ecology, upheaval in traditional morals—all of these have had and will continue to have profound, lasting effects on society—and in their wake gave you so many different challenges and opportunities than we made for ourselves. Along with the challenges must have come confusion, rebellion, the desire to be different—and to be an individual. Perhaps this explains your early choice of a college career in anti-pre-med or pre-anti-father. I wanted so much to help you and to advise you without unduly influencing you to a lifetime not of your choosing. I felt as if my role as a doctor-father was to play an arms length part and yet be there when you wanted and needed my support. I believe that when you made your decision to pursue medicine, it was a firm one and one of your own conviction. I believe you have found yourself and, in the process of choosing your medical school, experienced the agony of defeat and the satisfaction of achievement. The quality of education you will receive at Royal College depends (as with any school) upon your motivation. You have the disadvantage (?) of being far from home and the advantage of a fantastically broadening environment of a country and school long steeped in tradition and some of the giants of medicine as your predecessors—Graves, Colles, Stokes, to name just a few. I hope you take advantage of every educational opportunity offered you on a foreign soil—medical, cultural, and the horizon-enlarging perspectives that accompany travel.

Our path of recovery will require continued devotion and effort.

With your career choice and school selection, you have bought some problems: 1. Entering American medicine when you complete your studies. 2. Entering the practice of medicine in the midst of changes in medicine, enormous pressures from various groups demanding (and nearly dictating) changes in the ways medical care is delivered, confrontation with enormous bureaucracy and red tape at nearly all levels of medical practice, frustrations with the problems of organized medicine trying to cope with the complex issues of a changing society.

Surely you must have considered the impact of problems such as these upon your choice of medicine as a career, and it could make the future gloomy at worst and unpredictable at best. However (and this is the main point of my rambling), your future as a doctor is, and will always be, bright. You will always be able to make a living and to survive in spite of obstacles and roadblocks created by various elements of our society; there will always be a need somewhere for your services. Consequently, you will always be able to provide for your family. More importantly (much more importantly) you will always be able to do what one wishes when he is dedicated to the practice of medicine—to provide relief and comfort, if possible, to the sick; to ease the anguish of dying; to support those left behind in time of sorrow; to work happily and comfortably with your associates and colleagues; to teach those who come after you; to always be an avid student, even when you are a teacher; and to contribute to society in a myriad of civic and cultural ways. The pursuit of medicine with all of its problems today is still a noble profession and a marvelous way to spend a lifetime. We must not lose sight of our heritage and the history of devotion of our medical forefathers. This, and the ability to try to serve humanity, is our very basis for existing. We must not forget this when we are up to our ears in modern-day alligators and tilting with political and bureaucratic windmills. Then, in our later days, we will surely pluck the golden apples of the sun.

As always,

Your father



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Election Issues: Proposed Constitutional Amendments

the lobby



M. Robert Yakely, MD
Chairman, Council on Legislation
Carol Tempest
Director, Government Affairs Division

Four proposed constitutional measures and one statutory measure will be considered by the Colorado voters when they go to the polls on November 6. Ten other issues were the subject of petition drives but failed to receive the magic number of registered elector signatures. This number is equal to five percent of the votes cast in the last election for Secretary of State or a total of 47,639 signatures.

Amendments 1 and 2 were referred by the legislature; amendments 3 and 5 are initiated measures placed on the ballot by petition of the registered electors. All four of these amendments are constitutional amendments and if approved by the voters, could only be revised by a vote of the electors at a later general election.

Amendment 4 is an initiated statute and if approved by the voters could be changed by passage of a bill by the legislature.

Your Government Affairs Division has assembled the background information on all of these proposals and can supply you with information pro and con on each of them. Please call if you need material because lack of space precludes our listing the arguments.

Amendment No. 1—Constitutional Amendment Proposed by the General Assembly

Ballot Title: An amendment to article IV of the constitution of the state of Colorado, concerning the appointment of the commissioner of insurance by the governor with the consent of the senate, and exempting the commissioner from the state personnel system.

Provisions: The proposed amendment to the Colorado Constitution states that the governor shall nominate and, by and with the consent of the senate, appoint the commissioner of insurance to serve at his pleasure, and the state personnel system shall not extend to the commissioner of insurance.

Amendment No. 2—Constitutional Amendment Proposed by the General Assembly

Ballot Title: An amendment to article IV, XIV, XX, and XXI of the constitution of the state of Colorado, providing that a person must be a registered elector in order to vote for state elected executive officers, to vote for removal of a county seat, to vote on the striking off of county territory, to sign a petition for or to vote on county home rule, to vote on the formation, merger, election of members of governing bodies, and the functions of service authorities, to vote on a franchise relating to any street, alley or public place of a home rule city, to sign a petition for or to vote on municipal home rule, to sign a petition for or to vote on recall of state and local elective public officers, and applying to registered electors the percentage for determining the number of signatures on home rule petitions.

Provisions: The proposed amendment to the Colorado Constitution would substitute the term "registered elector" for "qualified elector" in a number of sections of the constitution. In general, this modification would mean a change in signature requirements for initiating, amending, or repealing a county or munciple home rule charter and for the recall of state, county, and municipal officers. A petition to adopt, amend, or repeal a municipal home rule charter would require signatures of five percent of the registered electors, rather than qualified electors. A similar change would be made in the section regarding the adoption, amendment, or repeal of county home rule.

Petitions for the recall of the elected state officers would have to be signed by registered electors, rather than qualified electors. The number of signatures required to initiate a recall election would remain at 25 percent of the entire vote cast for the respective office in the last election. A similar change from qualified to registered electors also would be applicable for recall of county and municipal officials. Reference in the constitution to the maximum number of signatures required to initiate a recall election for a municipal official would remain at 25 percent of the vote cast for the applicable office at the last election.

Other technical changes in which the term "registered elector" would be substituted for "qualified elector" include those relating to the casting of votes for:

- candidates for state office (governor, attorney general, secretary of state, and treasurer);
- changing the location of a county seat;
- changing county boundaries;
- formation and merger of service authorities, the election of the governing body thereof, and for the approval of the functions, services, and facilities of service authorities;
- adoption, repeal or amendment of a county or municipal home rule charter;
- recall of state elected officials; and
- recall of county and municipal elected officers.

Finally, the proposal would amend section 4 of article XX, Colorado Constitution, to require that "registered electors," rather than "qualified taxpaying electors," would have to approve franchises relating to any street, alley, or public place in a home rule municipality.

Although section 4 refers to only the city and county of Denver, the ballot title points out that section 4 applies to all home rule municipalities. Section 6 of article XX grants the powers in section 4 to all home rule municipalities.

Amendment No. 3—Constitutional Amendment Initiated by Petition

Ballot Title: Shall there be an amendment to article V of the Colorado Constitution prohibiting use of public funds by the state of Colorado or any of its agencies or political subdivisions to pay or reimburse, directly or indirectly, any person, agency or facility for any induced abortion, but permitting the general assembly, by specific bill, to authorize and appropriate funds for medical services necessary to prevent the death of a pregnant woman or her unborn child if every reasonable effort is made to preserve the life of each?

Provisions: The proposed amendment to the Colorado Constitution states: No public funds shall be used by the state of Colorado, its agencies or political subdivisions to pay or otherwise reimburse, either directly or indirectly, any person, agency or facility for the performance of any induced abortion, provided however, that the General Assembly, by specific bill may authorize and appropriate funds to be used for those medical services necessary to prevent the death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preserve the live of each.

Amendment No. 4—Proposed Statute—Initiated by Petition

Ballot Title: Shall an act be adopted to provide for additional voter registration of qualified electors applying for a driver's license; to allow voter registration up to 25 days before an election; to provide that registered electors not voting in one general election will retain their registration, but may be placed on an "inactive" status if it appears they have moved from their address of registration; and to provide for the purging or making current of "inactive" voter registrations?

Provisions: The proposed statute would make three major changes in voter registration laws in Colorado: 1) procedures for purging or removing electors from the registration books would be revised; 2) qualified electors would be given an opportunity to register to vote at state driver licensing stations operated by the Colorado Department of Revenue; and 3) voter registration would be permitted up to 25 days before any general, primary, or other election for which registration is required.

Following a general election, each county clerk would be required to mail a notice to each registered elector who did not vote at the election. The notice would be to inform the elector that unless the elector requested to be withdrawn from registration his name would be continued on the registration book. Such mailings would be marked "Do not forward. Return to sender."

If a continuation of registration notice were returned as not deliverable, the county clerk would classify such elector as "inactive." An "inactive" elector who failed to vote in the next general election or who failed to make current his registration would have his name purged from the registration book. The "inactive" designation would be removed if the elector appeared at a registration site or poll before, or at, any election up to and including the subsequent general election. The "inactive" elector would then be eligible to vote after taking the proper oath.

CMS has convened several legislative task forces.

Beginning July 1, 1985, the proposed statute would require that driver's license examination facilities permit qualified electors to apply to register to vote at the time application is made for a driver's license, renewal of a license, correction of a license, or for the issuance of an identification card. A qualified elector could make application to register to vote at any driver's license facility regardless of his county of residence. A single application form for both driver licensing and voter registration would be provided for those persons wishing to register to vote. An automatic change of residence procedure for voter registration would be established for most persons notifying driver's license officials of a change in address.

Registered electors applying for a driver's license could register family members for voting. To be eligible for registration, family members would have to be qualified electors and would have to live at the same address as the registered elector.

Driver's license officials would be authorized to administer an election oath to those persons applying for voter registration and to those registered electors desiring to register family members for voting. The proposed statute also contains detailed technical provisions relating to voter registration forms, instructions, and deadlines to be followed by county clerks and other procedural matters.

Amendment No. 5—Proposed Constitutional Amendment—Initiated by Petition.

Ballot Title: Shall the Colorado Constitution be amended to provide for the conduct of casino gaming in Pueblo County as of July 1, 1985; to direct appointment of a commission to regulate and license casino gaming and the sale of alcoholic beverages in conjunction therewith, and to control an adjacent recreation area; to direct payment to the commission of license fees and up to ten percent of gross proceeds from casino gaming and to provide, after deduction of administrative and organizational costs from such payment, for appropriation of the balance for public schools and the medically indigent program; and to require the general assembly to enact laws to implement the amendment?

Provisions: Casino gaming, as defined by the amendment, would be restricted to a designated area of Pueblo County. Persons desiring to conduct casino games in Pueblo

County would be licensed by a proposed five-member casino control commission. The commission would be appointed by the governor with the approval of the Colorado senate. Qualifications, compensation, terms of office, and the powers and duties of the commission would be established by the general assembly.

The amendment sets forth a legal description of land owned by the state to be acquired and controlled by the commission for the purpose of casino gaming, including a separate parcel of land to be set aside for the purpose of family recreation. (The land described is part of the old Pueblo Honor Farm.) If the areas designated in the amendment could not be obtained for the aforementioned purposes, the commission would be directed to acquire other land in Pueblo County through eminent domain proceedings.

Persons applying for a gaming license would pay a fee to cover the costs of processing applications. Casino operators would pay license and renewal fees and a tax which could not exceed 10 percent of casino gross receipts. Revenues received by the commission would be distributed in accordance with the following priorities:

1) to pay the administrative expenses of the commission;

2) to pay for the operation and development of property under the jurisdiction of the commission;

3) to repay the state general fund for monies appropriated for start-up costs of the commission; and

4) to remit any balance to the state public school fund and the medically indigent program, 70 percent and 30 percent of said balance respectively.

The distribution of revenue under items (1) and (2) above could be revised by subsequent legislation enacted by the general assembly.

Persons obtaining a gaming license issued by the commission would be eligible to sell malt, vinous, and spirituous liquors for on-premise consumption. The proposed casino control commission would have exclusive authority to promulgate and enforce regulations for the sale of alcoholic beverages in the licensed casinos.

Under the terms of the amendment, "casino gaming" would not include the bingo, lotto, and raffles operated throughout the state by charitable organizations, or games authorized pursuant to the "Colorado Liquor Code," or the state lottery.

Finally, the amendment would charge the general assembly with enacting legislation to implement casino gaming, including the appropriation of funds to cover the organizational expenses of the proposed casino control commission.

Additional Notes: CMS has convened several task forces in the off-legislative season—tort reform, living wills, preventive and safety medicine (seat belts, motorcycle helmets, etc.), and others. We've reached deep into the community for participants and we'll be giving you an update on results in next month's *Colorado Medicine*.

In the meantime please be active politically in October, and most importantly, vote on November 6!

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3360

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auxiliary report



Mary Hanson, President
Colorado Medical Society Auxiliary

Plans for a New Year

"The Changing Face of Medicine" is a predominant theme when the subject of health care is addressed. The areas of concern for the well-being of our families change with the times as well. As we start a new year in the Colorado Medical Society Auxiliary, we will be planning ways in which these changing areas of concern can best be met.

You will notice the changed face in the picture accompanying the CMSA report. I was installed as president of the auxiliary in Vail in September and represent El Paso County. I am excited to carry on in a coordinated and consistent manner the activities already taking place, as well as using the opportunities presented in new areas of health education.

A primary focus for this year is trying to improve the public perception of the medical community. In the case of the physician's spouse, it has been suggested that we have no image at all to the public, particularly with regard to our volunteer efforts to improve the health and well-being of children, families and the general population. Auxilians are 80,000 strong across the country and there are 1,300 dedicated volunteers in the CMSA who are helping improve the quality of life for Coloradoans.

In the Colorado Medical Society Auxiliary, we hope to improve our image by building better public relations with the media. Plans include setting aside a day on which all organized county auxiliaries will be asked to invite members of the media from their communities to a reception. Target date for this event is late spring. The purposes of the reception are to honor the representatives of the media for their many contributions to the community and to establish one-on-one relationships with them. "Public relations" is not a negative concept. In the words of one practitioner, it's simply "doing good and taking credit for it."

At the county receptions, the media will be recognized for building awareness of health-related projects and programs in the community. Fact sheets and possibly a video of current health improvement projects in Colorado will be used to inform the media representatives of the many volunteer efforts going on in

Is there a doctor on the road or at the game?



The Committee on Medical Aspects of Sports of the Colorado Medical Society hopes to hear from physicians who share its members' interest and concern about medical coverage of running events and interscholastic athletic contests.

Please let us know if you are interested in participating in your community.

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Running Events: ☐

Names of sports: _____

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David C. Greenberg, MD
Chairman
Medical Aspects of Sports Committee
Colorado Medical Society
6825 E. Tennessee
Building 2, Suite 500
Denver, CO 80224

Name: _____

Address: _____

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Telephone: _____

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our state.

Communication is the key to success in this venture. Anne Morrow Lindbergh said that "Communication is as stimulating as black coffee, and just as hard to sleep after." There is a dual perspective to communicating, part of which is knowing what to say. The other part is listening. Careful planning to present the strong points of volunteer health care improvement and education will be a priority of this event.

Ongoing programs of the auxiliary include the Med-Vote '84 and Participation '84 programs, which have been vigorously pursued throughout the auxiliary membership. Our representative on the Prescription Drug Abuse Coalition has given our support in the area of school education. The impaired physicians' family and malpractice support groups are active and caring components of the auxiliary. Auxilians present many and various safety programs in schools throughout Colorado. All the programs and the health care education through volunteers requires a strong and vital membership.

Targeted for AMA Auxiliary involvement this year are five educational programs on prenatal and postnatal care: adolescent pregnancy, awareness and prevention of fetal alchohol syndrome (FAS), nutrition during pregnancy, hazards of smoking during pregnancy, and infant/child auto safety restraints.

These programs will be pursued, where needed and appropriate, throughout Colorado. Auxiliary involvement in these programs gives us the opportunity to protect the future--our future, and the future of those yet to be born.

Communication about auxiliary programs to the people of our state will help us gain support and awareness for ongoing projects and enlist help and direction for new ventures in health care volunteerism. George Eliot said, "What do we live for if not to make life less difficult for others?" I believe that the physicians' spouses of Colorado exemplify this idea.

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c.m.e. report

Ron Franks, MD, Chairman
Council on Professional Education
David Haggerty, Director,
Division of Professional Services

Update on Accreditation Policies

Several recent developments concerning the accreditation of CME programs will be of interest to our readers. The first concerns a statement on national vs. intra-state accreditation of CME programs, issued by the Accreditation Council on Continuing Medical Education (ACCME). You will remember that national accreditation means direct accreditation, by the ACCME, of programs focusing largely on national audiences; while intra-state accreditation, by the state medical society, indicates that the program is primarily engaged in serving its own staff or membership and operates primarily in its own immediate geographic area.

The statement reads as follows:

> A sponsor of continuing medical education which is accredited by its state medical society as an intra-state provider of CME is assumed to be serving the physicians in its own geographic area. It is not appropriate for an intra-state accredited sponsor to act as the sponsor for CME activities which are advertised nationally. If the sponsor wishes to advertise its CME activities nationally it may apply directly to the ACCME or seek joint sponsorship with a nationally accredited sponsor.

This policy has important implications for CME programs accredited by the CMS:

1. It is not generally permissible for CME providers accredited by CMS to market* activities nationally or beyond contiguous states (i.e., Kansas, Nebraska, New Mexico, Arizona, Utah, Wyoming).

2. It is particularly important for such providers not to enter into joint sponsorship with entrepreneurial organizations to capitalize on the national market that could be attracted to CME events in the resort areas of Colorado; this is beyond the scope of the accreditation that can be authorized by CMS.

3. It is permissible to market CME in other Colorado communities and those in contiguous states.

4. It is also permissible to award CME credit to visitors from other areas who attend your events as long as there is no attempt to market actively.

5. These guidelines do not preclude an intra-state accredited provider from directly sponsoring (but not jointly sponsoring) an occasional "national" CME activity while its overall program is designed primarily for physicians within the state or bordering states.

Although this has in fact always been the policy of CMS, we are aware that it may raise questions or cause problems for some CMS-accredited programs. Please contact Dave Haggerty, Director, CMS Division of Professional Services (321-8590), if you have such questions or problems; our intent is to be reasonable in our implementation of this policy.

The ACCME also has recently issued guidelines for commercial support of CME. They are reprinted here for the benefit of CMS-accredited programs which receive commercial support for some of their CME activities.

Council on Professional Education Hails New Chairman, Commends Dr. Moran

After several years of dedicated service to the Colorado Medical Society as Chairman of the Council on Professional Education, Dr. Patrick G. Moran is passing the gavel to Dr. Ronald D. Franks. Dr. Moran spearheaded the efforts which resulted in CMS becoming the accrediting authority for CME in Colorado. Also, he was a driving force in CMS becoming accredited, as a provider of CME, by the ACCME. These and the many other initiatives taken by Dr. Moran have served to establish CMS in a strong leadership role on the CME scene in Colorado. The council has voted to commend Dr. Moran for his great contribution; he deserves the appreciation of all of us for his hard work and leadership.

Dr. Ronald D. Franks, a psychiatrist who practices and teaches at the University of Colorado School of Medicine and who also works in the Office of Student Affairs there, brings much experience to the council. Already a member of the council, Dr. Franks also serves on the Committee on Medical School and Student Relationships and on the Board of Directors of the CMS Education and Research Foundation. Having Dr. Franks as council chairman will further strengthen CMS' relationship with the medical school. You will be hearing more from Dr. Franks in future columns.

Guidelines for Commercial Support of CME

While CME often receives financial and other support from non-accredited commercial organizations, accredited sponsors must assure the scientific integrity of their

*To "market" is defined as to advertise heavily with the intent of significantly increasing revenue from registrations; notifying colleagues in distant locations about Colorado meetings of potential interest is not considered marketing.

educational activities. The purpose of these guidelines is to help avoid inappropriate commercial influence in the planning, design, and implementation of CME activities by accredited sponsors.

1. Identification of CME needs, determination of educational objectives, and selection of content, faculty, educational methods and materials must be undertaken by the accredited sponsor's appropriate educational planning committee of physicians, acting independently of any commercial source. Similarly, evaluation must be designed and performed by the accredited sponsor. Accredited sponsors will be held responsible for the content, quality and scientific integrity of all CME activities.

2. Generic names should be used in presentations and discussions.

3. When commercial exhibits are part of the overall program, arrangements for these should not influence planning of the CME activity.

4. Accredited sponsors are responsible for the quality, content, and utilization of enduring CME materials prepared with the support of commercial organizations.

5. Financial aid must be acknowledged in printed announcements and brochures; however, reference should not be made to specific products. Dispersal of residual funds should be the responsibility of the accredited sponsor.

6. Commercially-supported social functions at CME meetings should neither compete with, nor take precedence over, the educational events.

In other CME-related developments, the CME Committee of CMS is preparing for the re-accreditation of CMS by the ACCME next spring when our initial two-year accreditation period expires. In connection with this, the CME Committee and the Council on Professional Education gained approval from the CMS Board of Directors to place a CME mission statement up for approval by the House of Delegates at the recent CMS Annual Meeting. Such mission statements are required by the ACCME Essentials to ensure an organization's commitment to CME. It is hoped that, by the time you read this, the following statement will have been ratified and incorporated into the CMS bylaws:

> The Colorado Medical Society seeks continually to develop CME programs and to improve the quality of continuing medical education for the physicians of Colorado through the Society's educational programs and activities.

With this mission statement, the Colorado Medical Society not only affirms its commitment to CME but also sets for itself a standard of excellence.

Conomikes Practice Management Workshops and Resident Workshop Planned

The Colorado Medical Society will again sponsor the popular Conomikes practice management workshops for physicians and their office staff. These workshops are particularly important now as Congress has implemented the Deficit Reduction Act, which will have a negative impact on physician income. One way for you to meet this challenge is to reduce your overhead expenses and streamline your office procedures—these workshops are designed to help you do just that! All events will be held at the Cherry Creek Inn, 600 South Colorado Blvd., Denver. Dates and schedule are as follows:

Practice Management Workshops

Personnel Management Techniques (Tuesday October 30, 1984—8:30 am–Noon)

Personnel Leadership and Communications (Tuesday October 30, 1984—1:30–5 pm)

Better Collections, Billing & Insurance (Wednesday October 31, 1984—8:30 am–Noon)

Reception and Patient Flow Techniques (Wednesday October 31, 1984—1:30–5 pm

What's New in Ear, Nose and Throat

ENT Symposium for Primary Care Physicians

Lectures to Include Current Controversies in ENT

Sponsored jointly by
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Dr. Paul H. Dragul, Director

Colorado Medical Society
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Saturday, November 10, 1984 (8 AM - 4 PM)
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Registration: $40 — Lunch Included

For further information, contact:
Associates of Otolaryngology
Suite 500, 950 E. Harvard Ave.
Denver, Colorado 80210
(303) 744-1961

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Computers in Medical Practice (Not a technical course in data processing) Thurs., Nov. 1, 1984—9 am–4 pm (1 hr lunch break)

Practice Marketing Techniques (Fri., Nov. 2, 1984—9 am–4 pm (1 hr lunch break)

Establishing Yourself In Medical Practice (For residents and other physicians now entering private practice) November 8-9, 1984

The first day will be a full day, from 8:30 a.m. to 5:00 p.m. The second day will run from 8:30-noon, with an optional afternoon seminar (at no extra charge!) featuring experts from the banking, legal, accounting and tax advising professions, and a special presentation on professional liability insurance.

If you have not received our mailings and would like more information, please contact us immediately: CMS Division of Professional Services (321-8590).

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Continuing Medical Education Teleconferences Planned for 1985

Bolster Your CME Program—Subscribe Now!

As you may know, the Colorado Medical Society, in a joint project with the University of Colorado School of Medicine, provides continuing medical education programs via teleconferencing to subscriber hospitals in Colorado and adjacent states. These programs are focused primarily on the educational needs of general and family practitioners in rural areas or other settings where it often can be difficult to obtain speakers for CME activities. CME teleconferencing has proved quite beneficial to our subscribers; we think it can do the same for you!

We hope you will consider subscribing to this program, or renewing your subscription if you are already "in the system." Monthly one-hour lecture/discussions are presented on the third Wednesday of each month at 7:30 a.m. Handouts and slides are sent in advance, and the UCSM handles all CME recordkeeping. The teleconference hookup allows participants at all sites to join in questions and discussions. Expert faculty are selected from medical schools and other locations.

The teleconferencing program runs on an 11-month schedule, January through November. If you think you would be interested in this quality, low-cost CME program, please contact us immediately. If you have questions, please don't hesitate to ask. If you already subscribe to this program, we need to hear from you, too, since subscriptions must be renewed each year to remain active. Please contact the CMS Division of Professional Services (321-8590) if you have any questions or problems.

Cigarette Smoking Found To Impair Healing

There is a direct association between cigarette smoking and the ability to heal following a facelift, according a study done by Dr. Thomas D. Rees, a plastic surgeon affiliated with the Manhattan Eye, Ear and Throat Hospital. Patients who smoke have 12 and a half times the chance of developing skin slough than patients who do not smoke, he said. Skin slough is the shedding of tissue which dies when a significant portion of blood supply fails to reach the skin and it results in delayed healing and more noticeable scar formation.

To confirm his long-held suspicion that smoking affects healing, Dr. Rees reviewed the records of 1,186 consecutive patients who had undergone facelift surgery from 1975 through 1981. One-hundred twenty-one patients had evidence of skin slough. Dr. Rees was able to contact 91 of these patients, or 80 percent, who admitted to smoking more than one pack of cigarettes a day. Eighteen patients, or 24 percent, denied that they smoked. Dr. Rees thus determined that 74 percent of the skin sloughs observed were due to smoking.

"Because nicotine constricts blood vessels, its impact on healing is compounded in surgery where the blood supply to facial skin is already temporarily reduced," he said. "This finding may be of some comfort to surgeons whose patients experience skin slough, because the condition can be blamed—to some extent, at least—on the patient's smoking habits."

As a result of his findings, Dr. Rees now accepts for facelift surgery only those patients who agree to stop smoking 10 days prior to surgery and abstain for three weeks afterward. "Because an appreciable part of every surgeon's practice consists of smokers," he cautioned, "the implications of this study, in terms of patient selection and preoperative counseling, seem considerable."

The American Society of Plastic and Reconstructive Surgery sponsors a free referral service to help prospective patients locate nearby active members who are certified by the American Board of Plastic Surgeons. The telephone referral number, in Chicago, is 312-856-1834. It is answered 24 hours a day. A list of certified plastic surgeons is available by writing to The American Society of Plastic and Reconstructive Surgeons, Suite 1900, 233 North Michigan Avenue, Chicago, Illinois 60601.

Dr. Butterfield Given Distinguished Service Award

The Distinguished Service Award for outstanding contributions in obstetrics and gynecology was recently awarded to Denver pediatrician, L. Joseph Butterfield, MD, at the 32nd Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in San Francisco.

Dr. Butterfield was cited for his efforts to help coordinate obstetrics and pediatrics to help women deliver healthy babies. He is the first pediatrician to receive the award.

Dr. Butterfield is chairman emeritus of the Department of Perinatology and the director of the Office of Regional Program Development at The Children's Hospital of Denver. He is well known for establishing neonatal care programs in the Rocky Mountain Area.

His activities on both the local and the national levels include work with the March of Dimes Birth Defects Foundation, the Colorado Perinatal Care Council, the American Academy of Pediatrics, the American Medical Association and the Denver and Colorado medical societies. He is currently chairman of the section on perinatal pediatrics of the American Academy of Pediatrics.

In addition to serving on the editorial board of *Perinatology/Neonatology* and as a consultant to several lay magazines, Dr. Butterfield has written more than 50 scientific articles.

Guide For Medical Groups Published

Meeting the Health Care Needs of Business: A Guide for Medical Groups is the title of a new monograph published by the Center for Research in Ambulatory Health Care Administration (CRAHCA). The publication discusses the importance of communication and interaction between medical groups and the business community in order to curb the spiraling costs of health care.

The editor, Bettina D. Kurowski, DPA, is an associate professor and director of the graduate program in health services administration at the University of Colorado. The monograph is available from CRAHCA for $20.00. For more information, write or call CRAHCA, an affiliate of the Medical Group Management Association, at 1355 South Colorado Blvd., Denver, Colorado 80222, 753-1111.

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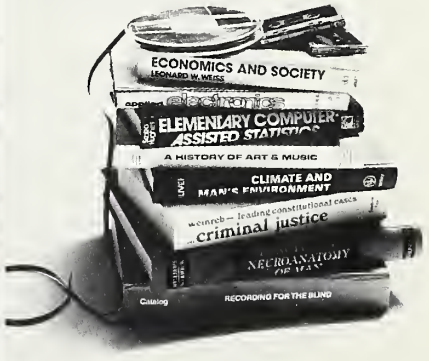
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Victory in Brighton County Court

Editor's Note: Recently CMS went to court in a successful effort to protect the health and safety of Colorado high school students, as well as to defend the professional rights of Colorado physicians. CMS, along with the Colorado High School Activities Association and three Colorado school districts, won a lawsuit (Colorado Chiropractic Association, et al. v. School District No. 28J et al; 2 July 1984) which sought to prohibit Colorado high schools from enforcing a rule which states that only MDs and DOs can perform sports physicals for high school students. The following account of the lawsuit was written by CMS Attorneys Lawrence M. Wood and Constance B. Wood.

Approximately a year ago, the Colorado High School Athletic Association, a private nonprofit organization which sets guidelines for participation in school athletics, was approached by the Colorado Chiropractic Association, which was seeking to change the rule which now requires that sports physicals for high school students be performed only by doctors of medicine and doctors of osteopathy. The chiropractors wanted to change the rule to permit chiropractors to perform such examinations as well.

At the CHSAA annual meeting in April, 1984, after strong and persuasive efforts by Colorado Medical Society and other organizations not to change the rule, the association's members agreed to study the issue for a year and discuss again at the annual meeting in 1985.

The Chiropractic Association then filed suit in Adams County District Court. CHSAA and three school districts, School District No. 28J, County of Arapahoe, School District No. 60, County of Pueblo, and School District No. 70, County of Pueblo, were named defendants. The plaintiffs were the Colorado Chiropractic Association and Thomas P. Pool, D.C., a chiropractor practicing in Pueblo.

The suit demanded that the school districts and CHSAA be enjoined from enforcing the rule requiring that high school physicals be performed by MDs and DOs only, and for a declaratory judgment that the CHSAA has no authority to issue the rules and regulations regarding high school physicals.

On July 2, 1984, the plaintiffs appeared in court, without a contested hearing, and obtained a temporary restraining order enjoining the defendants from enforcement of the rule. At the same time, the case was set for full hearing, on July 12, regarding the plaintiffs' right to an injunction.

CMS was informed by CHSAA of the lawsuit and the restraining order and urged to intervene in the lawsuit in order to uphold the rule. At its meeting on July 6, the CMS Board of Directors authorized medical society attorneys Lawrence M. Wood and Constance B. Wood to file a motion to intervene. The firm of Johnson, Mahoney and Scott, PC, was also retained to provide medical-legal advice and cross examination.

The motion to intervene was granted, over the strenuous objections of the Chiropractic Association.

At that same hearing, the court set the case for hearing on the merits of the chiropractors' demand for permanent injunction, for August 20, 21 and 22. The temporary restraining order was continued during that interval, thus effectively denying the school districts and CHSAA the right to exclude chiropractors from performing sports physicals in the meantime.

The attorneys, with the assistance of CMS staff, began to prepare for the trial. Preparation included the location of witnesses and documents needed to be offered in evidence, the interviewing of prospective witnesses, the discussion of prospective testimony with the selected witnesses, legal research of applicable statutes and case law and a substantial search for text and other materials which would be relevant to the qualifications of chiropractors for the examinations in question.

Arrangements were made to take the deposition of the plaintiff, Thomas Pool, on August 11. Paul Scott, MD, JD, of the firm of Johnson, Mahoney and Scott was enlisted to take that deposition, cross-examine the witness at trial and cross-examine other chiropractic witnesses.

At his deposition, the plaintiff refused to answer the most vital questions regarding the scope and nature of the physical examinations he would make of high school athletes, or the exact manner in which he would conduct such examinations. Motion was filed with the court to compel answers to those questions. These motions were based upon the position of the defendants that CHSAA and the school districts had a right to make a requirement for examinations by physicians only, and that chiropractors were not qualified by training and experience, nor authorized by law, to perform such examinations.

On August 20, 1984, the case came on for hearing by Judge Philip Roan, who then elected to hear extended oral arguments prior to the commencement of trial. In a hearing which lasted approximately three hours, the positions of all the principal parties were thoroughly argued. Gerald Caplan, of the firm of Caplan and Earnest, Boulder, Colorado appeared on behalf of the CHSAA and one of the school districts. Lawrence M. Wood argued the case for CMS. The Chiropractic Association was

represented by Robert Ozer.

The judge concluded that his decision in this case was controlled by applicable legal authorities, and decided not to hear evidence on the subject. At the close of the argument, he indicated that he wished to take the case under advisement, in order to give himself an opportunity to study the decisions and statutes which had been argued.

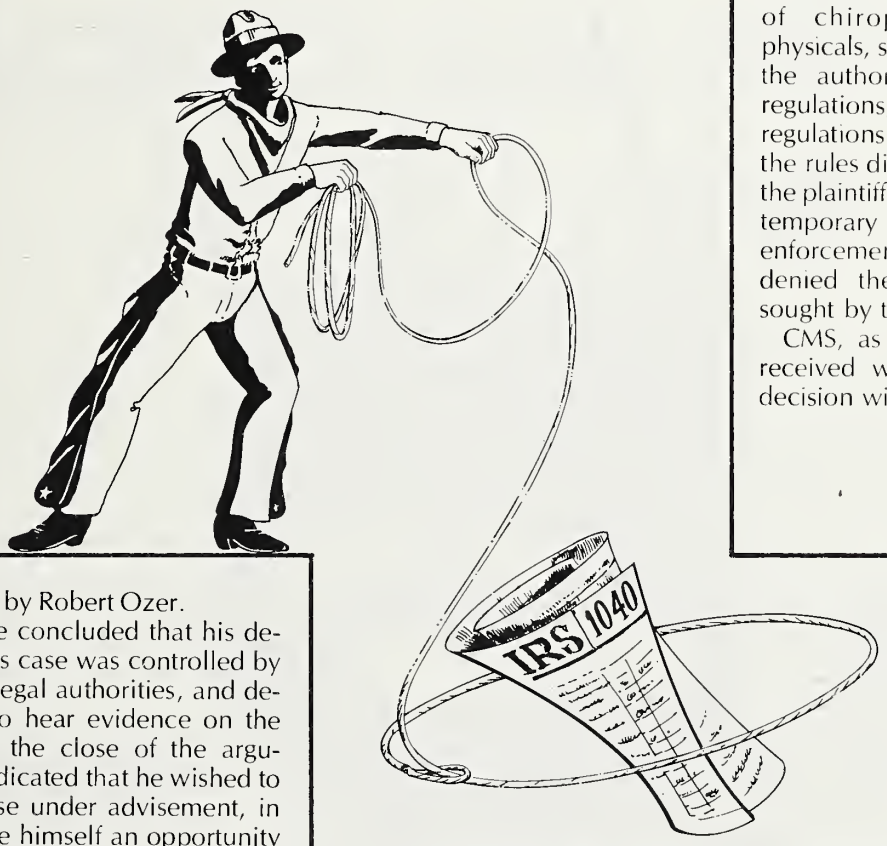
The CMS position in the case was strongly supported by a decision of the Colorado Supreme Court, in the case of *Colorado Chiropractic Association v. Colorado,* 171 Colo. 395, decided in 1970. In that case, the Chiropractic Association had sought legal authority to sign death certificates, as attending physicians. At that time, there was no legal definition, either by law or court decision, of the meaning of the term "physician". The court was left to make that decision on the basis of limitations on chiropractic practice, as defined by the Colorado chiropractic licensing law. The Supreme Court held that, primarily because of the limited scope of practice of chiropractors, they were not qualified to make those judgments necessary to establish the cause of death as required by a death certificate and that the term "physician" includes only doctors of osteopathy and doctors of medicine. A persuasive list of cases from other states support that conclusion.

Judge Roan's decision was received on August 30. The court's ruling, which did not expressly consider on the legality or qualifications of chiropractors to perform physicals, stated that the CHSAA has the authority to issue rules and regulations, that these rules and regulations are reasonable, and that the rules did not violate the rights of the plaintiffs. The court also lifted the temporary restraining order aginst enforcement of the CHSAA rule and denied the permanent injunction sought by the plaintiffs.

CMS, as of this writing, has not received word as to whether the decision will be appealed.

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— Will Rogers



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A Coalition That Works:

Medical Indigent Care in Pueblo

Editor's Note: The following article was written by Peggy Fogel, executive secretary of the Pueblo Medical Society.

More than 3,000 medically indigent families are receiving health care in Pueblo, thanks to the Pueblo Community Health Center. This effort was begun in 1982 by then-President of the Pueblo Medical Society, Robert W. Dingle, MD.

In July, 1982, the existing federally-funded health center lost its federal funding. Dr. Dingle saw that a need had been created for medically-indigent health care and called a meeting of people from local hospitals, the health department, dentists and representatives of the defunded health center. This group, agreeing that this health care need was a community-wide problem, expanded to include pharmacists, representatives of Pueblo City Council, the Pueblo county commissioners, the local Human Resources Commission, Department of Social Services and the U.S. congressional offices (Senators Armstrong and Hart and Representative Kogovsek).

The goal was medical care for people in the community who had no health insurance and who met federal income guidelines. The group, which called itself the Pueblo Community Coalition, aimed at spending funds of care and the least possible amount of money on building, equipment, staff, etc. PCC applied for state and federal funds, with much assistance from Dr. Frank Traylor and the Colorado Department of Health.

The Colorado legislature, with a lot of push from Representative Bob Kirscht and Senator John Beno gave PCC $49,000 in emergency funds in March, 1983. In April, 1983, PCC opened its doors. The Department of Social Services handled patient eligibility and screening and physicians and dentists volunteered their services. Primary care was contracted through the Southern Colorado Family Medicine program (part of the University of Colorado Health Sciences Center) for family practice resident physicians. Colorado State Hospital gave PCC free office space and local hospitals volunteered to take care of records and billing and



Robert W. Dingle, MD, and Judge Patti O'Rourke

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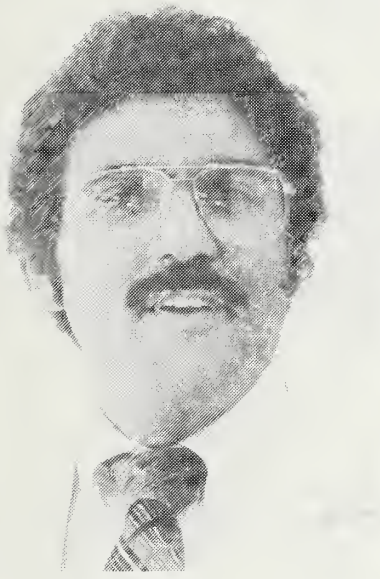

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Haydee C. Kort, MD



Drew A. Kovach, MD

handle press releases to the media. Pharmacists provided drugs at cost.

The coalition gave outpatient care only, mostly urgent, emergency care because of limited monies. PCC got a boost with Pueblo City and County funds of $33,000. Next the coalition was successful in obtaining federal funding of $370,000. The coalition hired a director and one staff person. Then PCC incorporated and took the name of Pueblo Community Health Center, Inc.

During this time, Pueblo's economy grew worse, due in part to the recession and CF&I lay-offs. Unemployment shot up and the need for Pueblo Community Health Center's services increased dramatically. Additional federal funds of $93,500 were granted to PCHC because of the severe unemployment.

Dr. Dingle stayed on the PCHC board, giving hours of his time as did a number of other physicians. He is still on the board today. The board has had many difficult decisions to make, and has never had enough money to care for all the health needs. Somehow the board has managed to solve its problems and kept the program together. Local media and providers (physicians, dentists, pharmacists, hospitals, social services) have cooperated amazingly.

Today all patients are asked to pay $3 for each physician or dentist visit and $1 for each prescription. Beyond this, there is a sliding scale of payments based on income and family size.

PCHC is a community-wide group and becoming even more representative of the community all the time. Six consumer representatives were added to the board recently. Other principals involved with PCHC include Judge Patti O'Rourke, chairman of PCHC; Jay Lowrey, executive director, and Haydee Kort, MD, the director of the Colorado State Hospital.

Pueblo County Medical Society has been involved in this community effort in many ways, from meetings and phone calls to consultations, advice and patient care. Others involved, besides Dr. Dingle, include board member Muryl Laman, MD; society executive secretary and board member Peggy Fogel; and Drs. Mary Berg, Robert Stelle and Drew Kovach, all directors of the Southern Colorado Family Medicine Program. Also involved have been many resident physicians who are members of the medical society. One hundred sixty-nine Pueblo physicians are referral doctors for the program. Approximately 90 percent of Pueblo's physicians are involved in the program.

From only 33 medically-indigent families receiving care in 1982 to 3100 today is quite a jump. PCHC has, due to the efforts of Dr. Dingle and so many others, become a health care program truly representative of the Pueblo community.



Wayne Kohan, MD, shown with reluctant patient Andrea Kasan as Andrea's mother, Mary Kasan, looks on.

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Polio Survivors Find Support

Editor's Note: The following interview was written by Publications Editor Sheila Swan.

Tom Boyce spent a year in the hospital, had countless operations, and wore braces on his legs until he was 19. He says now he's not about to go back to that way of life again. Mr. Boyce, born in 1949, is one of thousands of Americans who contracted polio during the epidemics of the late 1940s and early '50s. Many of these people, who lived normal lives for many years and were supposedly recovered, are now experiencing polio-like symptoms again.

Approximately two years ago, Mr. Boyce began to experience extreme fatigue, muscle cramps and spasms and a numbing feeling in his legs when he drove a car. He went from doctor to doctor, looking for an answer to his health problems. The physicians prescribed various remedies, including muscle relaxants. He himself tried various home remedieds. But no-one ever recognized what some physicians are now calling "post-polio syndrome." "One doctor even told me I was neurotic. But I knew I hurt and I wanted to know why," he said in a recent interview.

Then one night, several months ago, Mr. Boyce was watching *ABC World News Tonight* on television when he discovered what his symptoms might mean. The news show featured a segment on the Roosevelt Warm Springs Institute in Georgia, which had just sponsored its second symposium on post-polio syndrome. "The show described a lot of the symptoms I was going through. I was horrified," he said. The show inspired Mr. Boyce to try to find out more about post-polio syndrome. After calls to local TV stations and various health care organizations couldn't provide him with any information, Mr. Boyce finally called ABC-TV in New York. From ABC, he was able to obtain the phone number of the Warm Springs Institute.

When he contacted the institute, staff there began sending him information on their recent symposium, post-polio syndrome and on post-polio patient support groups, which had begun to form across the country. He found out that a woman in Colorado Springs, Geri Lynn Peek, was setting up a support group in that city. He contacted Ms. Peek and they began to work together to set up a group in Denver.

Their efforts have snowballed. Within just a few months, they have set up a liaison with Spalding Rehabilitation Hospital. Dr. Yagada Franotovic, a physician at Spalding, is working closely with the support group. (Dr. Franotovic, a specialist in rehabilitation medicine is a clinical instructor in the Department of Physical Medicine and Rehabilitation at the University of Colorado Health Sciences Center, as well as an attending physician at Spalding.) "The response has been absolutely incredible," Mr. Boyce said. Well over 100 people attended the second meeting, which took place at Spalding. Attendees included post-polio survivors from various parts of Colorado and Nebraska. Mr. Boyce said he has received calls about the newly-formed organization from as far away as South Dakota. Media publicity has helped; Mr. Boyce and Ms. Peek have been interviewed several times on local TV news shows.

Since that meeting, the support group, which has named itself the Colorado Polio Survivors Education Foundation, has filed for non-profit status and plans to incorporate. That's a lot of progress in a short time. Mr. Boyce noted that there are plans to form support groups in Grand Junction and Pueblo.

Because of the large amount of interest expressed in post-polio problems and treatment, Spalding now has plans to open a special unit for

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WHAT IS THE COLORADO MEDICAL SOCIETY?

The Colorado Medical Society is an association of professionals which:

"Promotes the science and art of medicine, the betterment of public health, and the welfare of the medical profession and the patients it serves; and promotes the similar interests of its component and district medical societies."*

Through the variety of physician councils and committees, the Colorado Medical Society continually monitors public health concerns, proposed legislation relating to these and other health issues, recommends legislation which will work toward the betterment of public health and welfare of the medical profession and the patients it serves.

In providing a continuing professional lobbying staff, the Colorado Medical Society keeps its physician members abreast of all current issues before the Colorado General Assembly and the Congress of the United States.

With regular publications, CMS is also able to inform members of pending and current actions as taken by the CMS Board of Directors and the Society leadership.

Colorado Medical Society yearly publishes the Physician's Directory, the most complete physician referral guide for private practice physicians, health care and medical education institutions, legal and insurance professionals, federal, state and local government offices and agencies.

A continuing program of public health information is conducted by the Colorado Medical Society and the Colorado Medical Society Auxiliary, working closely with public, private and parochial schools for the most complete program of health education and health awareness among primary and secondary school students.

Colorado Medical Society provides its own members with a continuing medical education program, year-around, involving numerous areas of specialty practice and general medicine. Such continuing medical education classes, seminars and symposia are accredited, and are announced in the monthly CME Calendar published jointly by the Colorado Medical Society and the Colorado Foundation for Medical Care.

Colorado Medicine is the official journal of the Colorado Medical Society, and in its short span of publication (under the present format) this magazine has been widely recognized for its excellence, both in design and editorial content. *Colorado Medicine* has become a widely-read publication carrying selective general advertising of a medical and health-related nature. Your inquiries about advertising and/or editorial contributions are invited. There are many other member services provided by the Colorado Medical Society, in keeping with the purposes, as stated in the Constitution of this 112 year old organization.

The Colorado Medical Society Department of Membership Services invites your inquiries concerning these myriad other services. Please contact the CMS Membership Services, (303) 321-8590, or write Member Services, Colorado Medical Society, 6825 East Tennessee, Building #2, Denver, CO 80224.

* from the Constitution of the Colorado Medical Society, as amended through September 10, 1981

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Continuing Medical Education

CALENDAR

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October 1984

4 **Neuropsychiatric Grand Rounds**—1–3 p.m. APA-approved course for Category I credit to examine the relationship of neurological and psychiatric disorders. Contact: James Scully, MD, Colorado State Hospital, 1600 W. 24th St., Pueblo, CO. (303) 543-1170.

4-5 **2nd Annual Critical Care Symposium**—Broadmoor Hotel, Colorado Springs, Colorado. Sponsored by Memorial Hospital. Credit: 11 hours AMA/CME. Fee: nurses, $30; physicians, $60. (Fee does not include lunch.) Contact: Jan Hodge-VonDebur at (303) 475-5675 or write: Continuing Medical Education, 1400 E. Boulder, PO Box 1326, Colorado Springs, Colorado 80901.

5 **Research Day**—Battenfeld Auditorium, University of Kansas Medical Center, Kansas City, Kansas. Credit: 7 hours AMA Category I. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

7-12 **Hilton Head OB-GYN Conference**—Mariner's Inn, Hilton Head Island, South Carolina. Fees: $335 for physicians, $225 for nurses, residents & allied health professionals. Contact: Conference & Institute Program, PO Box 11338, Denver, CO. (303) 629-5333.

11-14 **ACalifornia Conference on Applied Clinical Geriatrics**—The Napa Valley Veterans Home of California, Yountville, California. Credit: 25 hours AMA/CMA Category I. Tuition: $300 for physicians, $180 for all others. Contact: Pamela Stotlar, Office of Continuing Medical Education, School of Medicine, TB150, University of California, Davis, CA 95616. (916) 752-0328.

12-14 **Clinical Update 1984**—28th Annual Western Occupational Health Conference, San Francisco, California. Contact: Joe Donovan, c/o Western Occupational Health, 433 Palmer Ave., Aptos, CA 95003. (408) 688-9667.

17 **Diarrhea**—Vail Valley Medical Center, Vail, Colorado. 7 p.m. Speaker: E.V. Jones, MD. Credit: 2 AMA Category I hours; 2 hours AAFP prescribed credit hours applied for. Contact: Martin J. Rubinowitz, MD, 701 E. Colfax Ave., Denver, CO 802049

18-19 **Advanced Trauma Life Support**—Orr Major Hall, University of Kansas Medical Center, Kansas City, Kansas. Credit: 16 hours AMA Category I; 15 hours AAFP; 15 hours AOA 2-D. Fee: $350. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th & Rainbow, Kansas City, KS 66103, (913) 588-6124.

18-19 **39th Annual Internal Medicine Symposium**—University of Kansas Medical Center, Kansas City, KS. Credit: AMA Category I, AAFP. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd, Kansas City, KS 66103. (913) 588-4480.

21-25 **Hospital Medical Staff Conference & Hospital Trustee Forum**, Monterey Conference Center, Monterey, California. Contact: Estes Park Institute, PO Box 400, Englewood, CO 80151. (303) 761-7709.

22-26 **Clinical Management and Control of Tuberculosis**—Denver, Colorado. Tuition: $325. Physicians in training: $150. Contact: National Jewish Hospital, 3800 E. Colfax Ave., TB Course Office, Denver, CO 80206. (303) 398-1700.

23-24 **Medicine and Religion: The Family**—University of Kansas Medical Center, Kansas City, Kansas. Credit: AMA Category I, AAFP, CNE, SW. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd, Kansas City, KS 66103. (913) 588-4480.

24-27 **The American Academy of Clinical Anesthesiologists Fall Seminar**—Grove Park Inn, Asheville, North Carolina. Co-sponsored by East Tennessee State University Quillen Dishner College of Medicine for up to 11 hours of Category I credit. Contact: Donald G. Catron, MD, Program Director, American Academy of Clinical Anesthesiologists, Box 11691, Knoxville, TN, 37919-1691. (615) 588-6279.

25-26 **7th Annual Current Concerns in Adolescent Medicine: A Practitioner's Guide to Teenage Health Care**—The Warwick Hotel, 65 West 54th Street, at Avenue of the Americas, New York City, New York. Open to pediatricians, family practitioners, allied health professionals. Contact: Debra Mohr, Assistant to the Continuing Education Coordinator, The Division of Adolescent Medicine of the Department of Pediatrics, Schneider Children's Hospital, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042 or Ann J. Boehme, CE Coordinator, Long Island Jewish-Hillside Medical Center, New Hyde Park, NY 11042. (212) 470-2114.

25-27 **International Symposium on Implant Surgery (for the hand and upper extremity)**—Grand Rapids, Michigan at Blodgett Memorial Center and Amway Grand Plaza Hotel. Sponsored by the American Society for Surgery of the Hand. Contact: American Society for Surgery of the Hand, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

26-28 **Diagnostic Radiology Update Including Magnetic Resonance Imaging**—Lincoln Hotel, LBJ Freeway, Dallas, Texas. Fee: $300 ($175 for residents and fellows). Credit: 18 Hours AMA Category I. Contact: Dolly Christensen, Department of Radiology, UTHSCD, 5323 Harry Hines, Dallas, TX 75235. (214) 688-2502.

27-28 **Conference 6: Selected Topics in Rheumatology**—Sponsored by the Joe and Betty Alpert Arthritis Treatment Center, Rose Medical Center, Denver, Colorado. A multi-educational approach: formal presentations, panel discussion, workshops, patient sessions, self-quiz. Of special interest to internists, family physicians, orthopedic surgeons, nurse specialists, physician assistants, OTs and PTs. Credit: 11 hours AMA Category I, AAFP, nursing and physician assistant credits. Contact: Rose Medical Center, Office of Education, 4567 E. 9th Ave., Denver, CO 80220. (303) 320-2102.

treatment of post-polio patients in early October, according to Dr. Franotovic. She noted that all post-polio patients seeking treatment at Spalding will first be evaluated, "to rule out other possible health problems." Treatment may include a graded exercise program, "to reeducate the (weakened) muscles to a higher level of activity." In some cases, she added, patients may be fitted with new orthotic devices, such as the lighter-weight plastic braces.

Treatment will be multidisciplinary, she said. Physicians working with the post-polio unit will include orthopedic surgeons and respiratory specialists. Dr. Franotovic commented that it is hoped that the unit will become a regional center for the treatment of post-polio problems, adding that similar programs have opened in California and Texas.

It is important to note that controversy exists within the medical community and among polio survivors about the implications of the health problems many of these people are experiencing. Some feel that there may not be a connection with the polio infection. According to a recent article by Robert Gorski, editor of *Disabled USA,* entitled "Is Your Syndrome My Aging?," some physicians contend that post-polio patients may be feeling more severe and earlier effects of the aging process. Others believe that many post-polio survivors are having difficult health problems that do not respond to standard treatments or correspond to normal aging patterns.

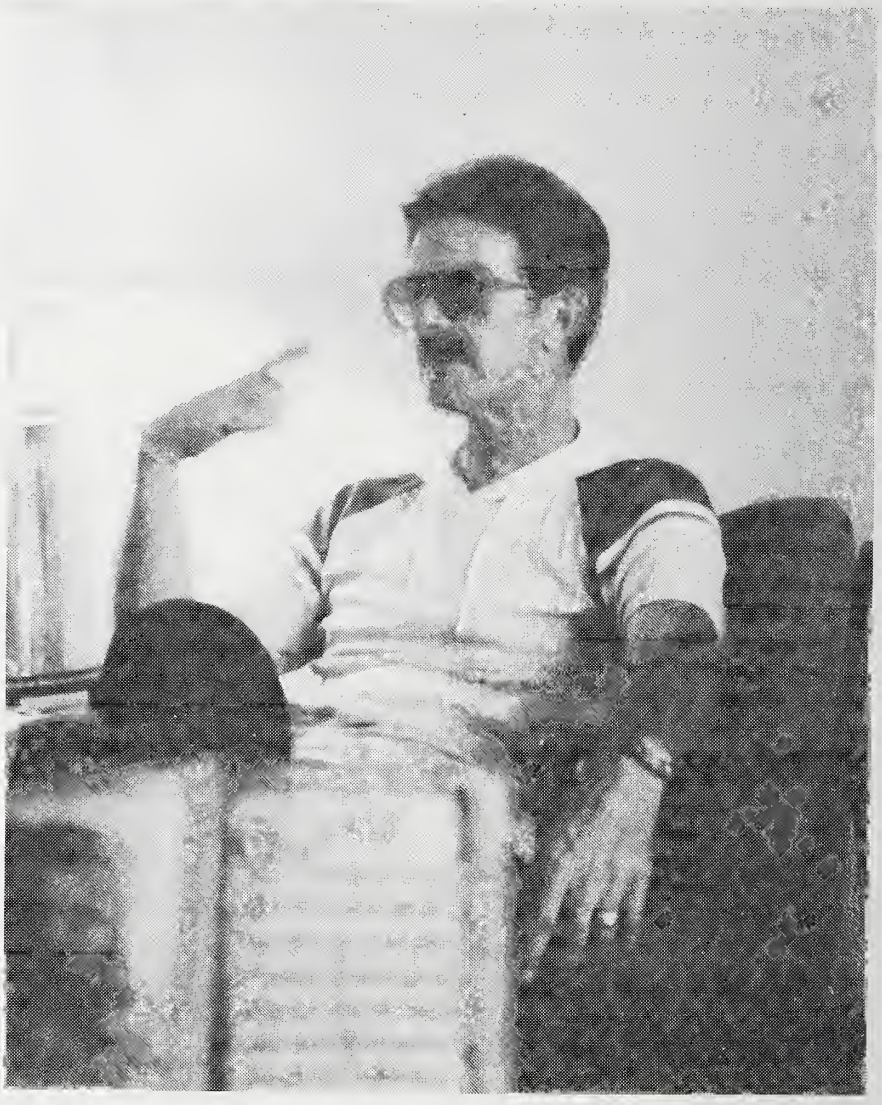
Several international symposia have been held within the last couple of years to inquire into the health problems, including possible late effects of polio, of polio survivors. One of these, mentioned earlier, was held in May, 1984 at the Roosevelt Warm Springs Institute for Rehabilitation in Warm Springs, Georgia. (For more information on this symposium, see the September issue of *Colorado Medicine,* p. 227). The 40 researchers and physicians at the Warm Springs symposium discussed possible causes for the health problems that polio survivors are experiencing. The possible causes discussed were premature aging of nerve cells damaged by the earlier infection with polio; reactivation of the polio virus; an immune reaction triggered by an unknown event; and a diminished ability with aging for polio-afflicted muscles to continue functioning normally.

Not surprisingly, Mr. Boyce is exultant about the response to the support group and to the prospect of a post-polio clinic. "What we hoped to accomplish was to show there was a special need for post-polio treatment—and we did it!" He added, "Two months ago we had nothing and soon we'll have a clinic."

He noted that, although the support groups can provide information and emotional support to polio survivors, it is important for them to get medical advice and proper health care. "Every polio survivor, regardless of whether he is experiencing symptoms, should see a doctor, or visit the clinic, and be thoroughly evaluated."

Physicians interested in learning more about post-polio treatment can call or write to Spalding Rehabilitation Hospital, 1919 Ogden, Denver, Colorado 80218; 861-0504. Information is also available from the Roosevelt Warm Springs Institute for Rehabilitation, PO Box 1000, Warm Springs, Georgia 31830.

Another source of information is a new publication entitled *Handbook on the Late Effects of Poliomyelitis for Physicians and Survivors.* The handbook was compiled by Gini Laurie, editor/publisher of *Rehabilitation Gazette* and co-edited by Dr. Frederick M. Maynard, Associate Professor of Physical Medicine and Rehabilitation, University of Michigan Medical School. For information on obtaining the publication, write to Gazette International Networking Institute, 4502 Maryland, St. Louis, MO 63108.



obituaries

LeGrand B. Byington, MD, of the Denver Medical Society, died July 21 in San Francisco. He was 90.

Dr. Byington was director of the Denver Department of Health and Hospitals from 1955 to 1964.

He was born May 23, 1894 in Iowa City, Iowa. He attended schools in Iowa City and was graduated from the University of Iowa in 1916 with a bachelor of science degree. He received his medical degree from the same university in 1919 and interned the following year at the Henry Ford Hospital in Detroit.

Dr. Byington received a master's degree in public health from Johns Hopkins University in 1939.

He married Alberta Kaa on May 27, 1926. They had a daughter, Kaa Byington Friendenwald.

From 1921 to 1953, Dr. Byington was a medical officer in the U.S. Public Health Service, serving in the U.S., Canada, Mexico and Europe.

He was certified by the American Board of Preventive Medicine and Public Health. Memberships included the American Public Health Association and the American Medical Association. He was very proud of his medical society affiliations; in a letter to the Colorado Medical Society in 1979, he commented that he had asked to be buried wearing his AMA "50-year" pin.

Archa Campbell ("Cam") Denman, MD, of the El Paso County Medical Society, died September 8, in Penrose Hospital, Colorado Springs, of complications from pneumonia. He was 85.

Dr. Denman, who had practiced medicine for 50 years, was for many years the only physician in the Cripple Creek-Victor area. He was coroner in Teller County for 46 years, the longest tenure for that position in county history.

He was still seeing patients up until the day he was stricken ill, although he had ceased performing surgery some years before.

He was born on May 23, 1899, in Buena Vista, Colorado. He attended schools in Denver and Colorado Springs. His father operated a gold mine in Cripple Creek.

Dr. Denman received his medical degree in 1930 at the University of Colorado and interned for a year at St. Joseph Hospital, Denver. He practiced in Denver for two years before moving his practice to Cripple Creek in 1934.

He married Wilhemina Mead of Greeley on April 19, 1939. She died in 1963. He married Lola Thomas Fay of Cripple Creek on February 14, 1965.

Dr. Denman was chief of staff at Cripple Creek Hospital and Hilltop Nursing Home from 1934 to 1978. He was a member of the staff at Penrose Hospital for many years.

He was also mayor of Victor for seven years, resigning when he moved his home, but not his office, to Cripple Creek.

Memberships included the American Society of Abdomenal Surgeons and the American Society of Family Physicians. Dr. Denman was also a member of the Masonic Lodge and Two Mile High Chamber of Commerce in Cripple Creek, as well as several fishing and hunting clubs.

He is survived by his wife, three stepsons, Jack T. Fay of Penrose, Colorado, Richard H. Fay of Cripple Creek and James L. Fay of Santa Maria, California; 10 grandchildren and three great-grandchildren.

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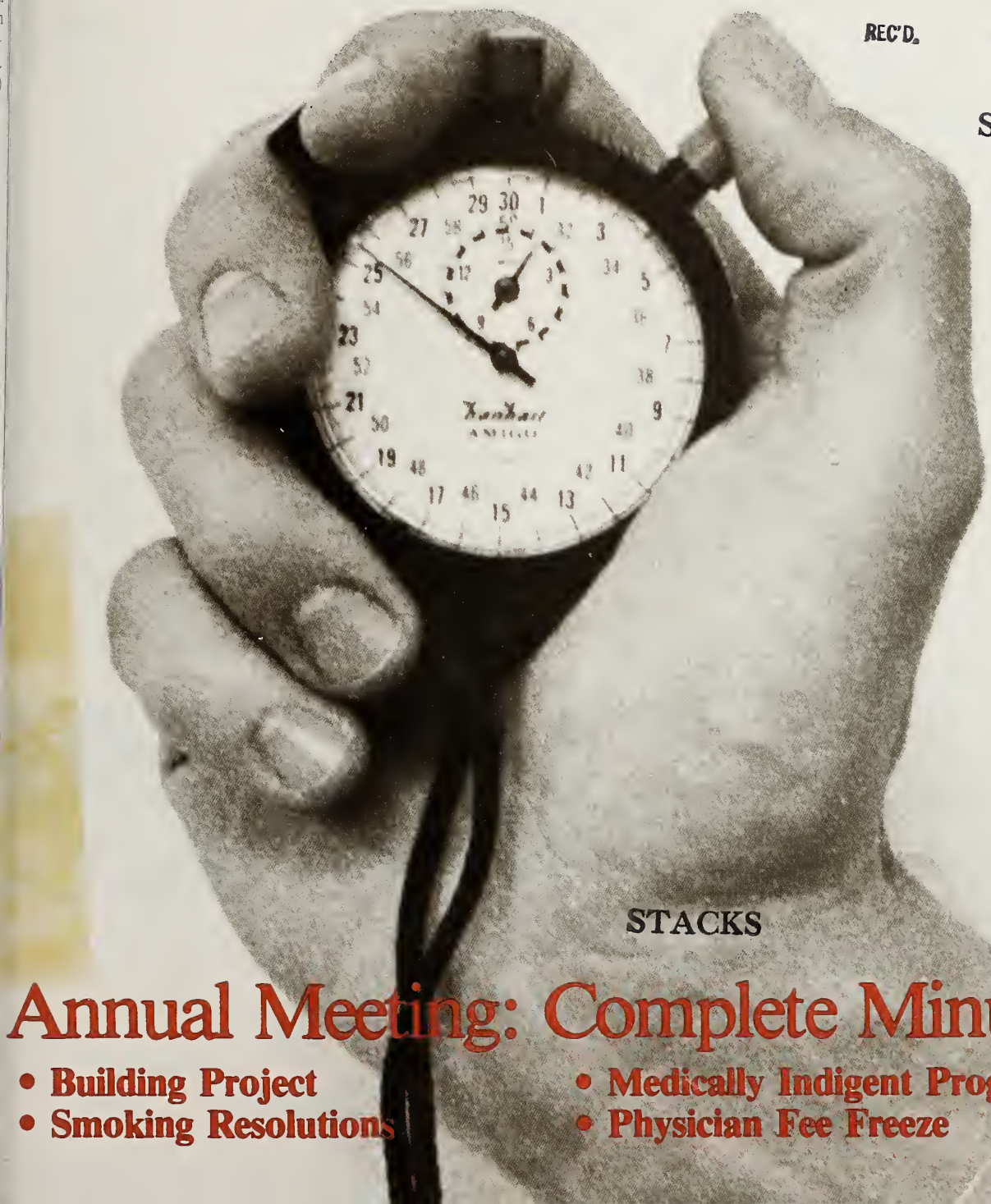
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This month's cover:

The CMS House of Delegates met September 20-22 at the Annual Meeting in Vail. A number of resolutions were passed regarding such important issues as the CMS building project, a voluntary fee freeze for Colorado physicians and a proposed program for the medically indigent. The minutes begin on p. 283.

Also this month: Physicians have become actively involved in the effort to educate the public about the dangers of smoking. The CMS House of Delegates passed two resolutions on this issue, one to limit or ban smoking in public places, and the other to ban smoking in health facilities. See p. 288.

In related stories, would banning cigarette advertising help stop smoking—and would it be constitutional? P. 289. Also, physicians can help in the fight against smoking right in their own offices—by boycotting magazines which carry cigarette advertising. P. 292.

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president's letter



W. Gerald Rainer, MD
President, Colorado Medical Society

Governor Lamm's Ideas on Health Care

Governor Lamm's address to the CMS House of Delegates at Vail on September 20 was politely received by an attentive audience. He outlined, with his usual clarity, some of the enormous problems facing the nation in the high cost of health care delivery. As usual, the statistics were alarming and his method of delivery produced the desired sobering effect. However, the proposed solutions, in some instances, are more provocative than practical. These were the usual proposals to decrease the number of physicians, close hospitals, and set priorities. All of these proposals are noble and well-intentioned; but the ability to accomplish these goals is more easily discussed than implemented in our current system. Although we would all admit to an excessive increase in the number of medical schools in the past two decades (many redundant and remote), and the impact that the number of schools has in the production of their role in the over-supply of physicians, how does one convince a congressman in Washington that an institute for medical education in *his* district is going to close its doors?

Governor Lamm did raise two issues which should be of more than passing interest to Colorado physicians. One is the proposal to reform the process and practice of malpractice litigation. For even suggesting this approach, we applaud him and pledge our support to work through the cumbersome attorney-controlled legislative system to try to bring about some welcome relief from this cervical albatross.

The second suggestion posed by the governor was the "change of the traditional relationship between hospitals and doctors," allowing hospitals to hire their own physicians. In this profit-motivated world of economics and with the distiction between "for-profit" and "not-for-profit"growing even dimmer, I'm not convinced that the suggestion of physician-hiring would affect total health care costs at all. In addition, the continued erosion of the patient-doctor relationship must not be allowed to proceed under the guise of cost containment. In spite of innumerable potential conflicts, this relationship between patient and physician still reflects the compassionate humanism of the practice of medicine that we must preserve and pass on to future generations of our followers. It is within this context that we have the best chance to insure *quality* of health care delivery and avoid being totally blinded by the shocking statistics of the overwhelming costs of our system.

Health care delivery—cost, access, methods, logistics, quality—is a societal problem and is not solely the responsibility of the physician or the medical profession in its broadest sense.

And, although we disagree with some of the solutions suggested by the governor, we appreciate the candor of his remarks and look forward to working with him and the legislature toward the solution of some of these enormous problems. Only with this approach do we have a chance to preserve our ideals and concepts of medicine as a noble and compassionate profession.

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Colorado Medical Society Auxiliary

Project Care Can Help Impaired Physicians' Families

"The great majority of physicians who complete rehabilitation programs can successfully return to the practice of medicine," according to Dr. Donald M. Keith, Chairman of the AMA Impaired Physicians Advisory Committee. This message came out of the AMA-sponsored Impaired Physicians Conference held recently in Secaucus, New Jersey. Dr. Keith also said that the number of physicians being referred to such programs represents only the "tip of the iceberg" of those needing help.

Last year, 45 state programs reported referrals of 1,087 impaired physicians, representing less than .003 percent of the nation's physicians. Dr. Keith noted that approximately 10 percent of physicians at some time in their lives will be impaired as a result of addiction to alcohol or drugs or because of a psychiatric illness. He added that "it's the same percentage (of impairment) as every other professional group, as far as we know."

Stress is a problem which affects the entire medical family. A spouse can contribute to the negative situation by denying that a problem exists, refusing to recognize symptoms, or by passively accepting the distance that the physician puts between himself/and the family. Often, family members in this situation feel isolated and neglected, even to the point of desperation and hopelessness.

In response to the increased awareness of stress in physicians' families, the Colorado Medical Society Auxiliary has begun a statewide program called Project Care. The

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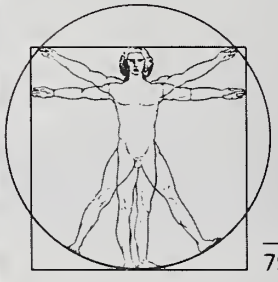
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program is designed to be a peer network for support of physicians' families under stress, and to help the spouse and family deal with the strain and stress of the medical marriage. Support strategies include establishing and maintaining a peer telephone network of trained volunteers, maintaining an active list of resources available in the local community, developing educational programs and publicizing effective educational tools and materials.

Project Care encourages representation from each county organization. Although these representatives meet at a state level to share expertise, each county develops a program to meet its specific needs. Nationally, Project Care endorses the AMA Auxiliary support of programs which answer the needs of medical families under stress.

Every physician spouse should be aware of the problems of stress and physician impairment. Early detection is more likely if physicians know that support and help from colleagues, agencies and administrators is readily available and cover-up of early symptoms is unnecessary.

Via Project Care, the auxiliary hopes to help bridge the gap caused by stress in the physician's family. We can only help, however, if physician families make use of the telephone network. The network is set up so that only first names are used; all communications are kept confidential. This listening and caring service provides information of resources available in Colorado. No advice is given; the thrust is to help impaired physicians and their families take that first critical step toward regaining healthy lives.

The auxiliary is in a unique position to provide a service which no other organization can provide: a forum for physicians' spouses to discuss with people who have like concerns the stress-related problems and pressures that take place in a medical family. Although much of the work of the auxiliary is given to community outreach, it is vitally important that time and effort also be given to the medical family and its concerns.

copic report



K. Mason Howard, MD, Chairman
Larry W. Thrower, President
COPIC Insurance Company

COPIC Becomes Licensed Insurance Company

Since its inception in 1981, COPIC has operated as a trust providing professional liability to members of the Colorado Medical Society. Because of your strong support, COPIC has surpassed all of its stated objectives as a trust:

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Exceeded projected surplus goals—COPIC surplus now exceeds $4,000,000;

Healthy investment performance—COPIC premium dollars have earned investment income over $2,500,000;

Licensed Colorado insurance company—As announced at the recent CMS Annual Meeting, COPIC has been issued its Certificate of Authority from the Colorado Division of Insurance and is now approved as a multi-line Colorado insurance company.

To qualify for its license COPIC had to undergo a vigorous scrutiny of its organization, including programs, financials, underwriting controls, claims and professional management. The state of Colorado has determined that COPIC has met all the criteria for licensure in the state. Everyone involved with COPIC has a right to be proud of this accomplishment! The transition from a trust to an insurance company will not affect the philosophy of COPIC. We are, more than ever, committed to the physicians of Colorado! We have proven that a physician-company can control its own destiny, provide a stable market, and price itself reasonably for the protection provided.

Recent Changes in the Malpractice Insurance Industry

Many changes are taking place in the insurance industry which directly impact the cost of delivering medical care. The insurance industry as a whole is suffering through one of the most difficult and costly periods in its long history. There are a few warning signals of concern, particularly to the professional liability insurance industry:

Jury awards and negotiated settlement amounts all over the nation continue to increase at phenominal rates. The frequency of claims and suits is also on the rise.

Heavy losses sustained by the reinsurers of "long tail" casualty business have caused a sudden tightening up of the reinsurance market. This means an increase in cost of reinsurance to the primary carriers as well as limitations on the types of insurance coverages available. Some reinsurers will no longer accept new business for occurrence type coverage, but will continue to offer claims-made reinsurance coverage. Historically, it is the reinsurers who first react to the ill winds of the industry.

Investment income, although still good, has levelled to more moderate rates from the high yields on bonds in 1980 and the bull market days of 1982.

Decreases in investment income necessarily affect the rates companies must charge, since this income is used to offset adverse loss results.

We cannot afford to ignore developing trends and warnings. In order to continue our healthy growth and

assure the success of COPIC Insurance Company, we must do the following:

Reserve our claim files adequately.
Invest carefully.
Develop strong, healthy relationships with our reinsurers.
Closely monitor trends in the severity and frequency of claims and suits.
Develop rates to cover the cost of claims and expenses, as well as anticipate adequacy of those rates for developing frequencies and increasing severity.

A recent claims audit by our reinsurer, North American Reinsurance Corporation, confirms that COPIC claims handling is timely, realistic, and that reserves are adequately set on all open claim files. COPIC's claim department has extensive Colorado medical malpractice experience.

COPIC's investment committee, with the expertise of Oppenheimer & Company, oversees the conservative investment of our funds, currently earning a yield over 12 percent on our portfolio.

The reinsurance contracts established in the COPIC Trust will remain in force, and parallel terms have been negotiated for the COPIC Insurance Company to protect our insureds on an occurence basis from potentially adverse experience. This relationship continues to be strong and provides the solid financial backing critical to the professional liability risk.

COPIC's risk managers are aware of the severe loss trends and have intensified loss prevention efforts. Claims data and individualized statistics are analyzed regularly to identify and recommend solutions to preventable problems. Our actuarial studies produced for the Colorado Division of Insurance indicate that COPIC will pay out $23,000,000 in losses by 1991; however, through careful management of our financial program, during the same time period a $10,000,000 surplus will also be accumulated as a buffer against unforeseen catastrophic losses.

Our commitment to the company's strength and future requires us to make decisions based on sound business judgment and good common sense. Following the advice of our consulting actuary, Victor O. Schinnerer and Company, and supported by our reinsurer, COPIC premium rates will be increased beginning January 1, 1985. Depending on individual specialty and limits purchased, the actual increase will range between eight percent and 19.5 percent. We are convinced that this amount is necessary to respond to those concerns playing a major role in the problems facing other insurance carriers.

There is no question that COPIC is successful and will continue this effort with your support. It will take the work and cooperation of each of us to assure that COPIC remains strong and deals with the problems of this industry. We intend to be here as long as physicians' liability is a fact of life.



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the lobby

CMS Initiates Controversial Legislation



M. Robert Yakely, MD, Chairman
Council on Legislation
Carol Tempest, Director
Government Affairs Division

When the legislature is not in session, the CMS Government Affairs Division usually allows itself a deep breath, a lowering of blood pressure, and some time to get caught up. This year has been different. It is a campaign year which means meeting and talking to candidates, but it also is a year in which we have convened four task forces with the express purpose of writing legislation and finding sponsors for those bills.

We have spent much time interviewing candidates for the legislature, sadly not reaching the eastern or western slopes except by phones (It is those two or three-day trips that must happen two years from now). Happily the visits have made a difference in the way CMS is perceived by both the current and hopeful candidates.

The task forces have been very successful and have resulted in CMS taking the lead position in some five or six bills. We have involved the interested community members in each of the task forces, and the discussions have been stimulating and effective. It appears that the following bills will evolve because of task force action:

1. Mandatory use of motor cycle helmets. Representative Carol Taylor-Little has agreed to sponsor this bill, and Dr. Stephen Cantrill is playing the lead physician role. The proposed bill would restore Colorado law to its 1976 version before mandatory helmets were repealed. A coalition is being formed.

2. Mandatory use of seat belts. A large coalition of people has been formed, representing basically the same groups that helped pass the child seat restraint legislation. Dr. Denis Elo is the involved physician. New York passed the first such bill this year, so the decision was made to look for 1985 passage in Colorado instead of the originally planned 1986. A bill sponsor is being sought.

3. Living will (death with dignity) legislation. This concept has been unsuccessfully introduced four times but may be passed this year. A task force composed of physicians, nurses, hospitals, hospices, the Roman Catholic Archdiocese, the Denver probate judge, senior organizations, ethicists, interested legislators, etc. has hopefully agreed to agree—it's a first!

4. Tort Reform. Again a mixed group (physicians, hospitals, legislators, insurors) has met and seems ready to propose a package of bills. At this time the bills appear to address a redefinition of exemplary damages, a collateral source law, a ceiling on damages, a "no-fault" approach to malpractice and an approach to malpractice similar to workman's compensation.

So it has been a busy summer and fall, but hopefully the groundwork has been laid for a successful legislative session. It promises to be by far the busiest session we have ever had both in terms of the number of bills to be introduced and the complexity of them. Election Day will give us our first clue, and hopefully the intensive work will have paid off.

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guest editorial

Roger Bermingham, MD

The New Medicine

Not too long ago a patient of mine died. She was 52 years old and the cause of death on her death certificate will most likely read, "cardiac arrest with shock." There is a space on death certificates that asks for contributory causes. While I doubt this will be filled in on this woman's certificate, it should read, "medically indigent."

It is unfortunate but, to my mind true, that a significant cause of this woman's death was that she was one of those people who fall in the grey area between eligibility for Medicaid and having enough money to either pay her hospital and doctors' bills or health insurance. For that reason she is now dead. I first became acquainted with Mrs. M a few weeks before her death. I was on call for our hospital emergency room, to which she had come with feelings of severe chest pain, shortness of breath and sweatiness. At that time her exam and electrocardiogram suggested angina. Because of her severe chest pain, I admitted her to the hospital for further evaluation and treatment.

Her chest pain resolved within a few days with medications but it became apparent that she would need further evaluation. I arranged for her to be seen by a cardiologist from Pueblo who comes out to our rural hospital. He saw her and agreed that she had bad angina and in addition had some changes in her electrocardiogram that were highly suggestive of bad disease in her coronary arteries. He recommended that she undergo cardial catheterization. He agreed to accept her as his patient knowing, as I knew, that she was medically indigent.

Before she could be transferred down to see him, Mrs. M experienced another bad bout of chest pain and was readmitted to the hospital. She was stabilized again and this time sent directly to the cardiologist. She underwent a cardial catheterization which showed that she had more than 90 percent blockage of all four of the main blood vessels going to the muscle of her heart. Given this situation, the cardiologist felt that Mrs. M would be a prime candidate for coronary artery bypass grafting.

Now Mrs. M's problems because of her indigence began. Currently there is no cardiac surgeon in Pueblo. If there were I suspect he might have taken this patient's case. The cardiologists in Pueblo normally refer their patients to private cardiac surgeons in Denver, who generally do not take indigent cases. For that reason we contacted University Hospital in Denver, which receives the vast majority of medically indigent funding in Colorado. University Hospital agreed to eventually see Mrs. M, but, because of the number of indigent cases already seen at the hospital that month, Mrs. M would have to wait at least six to eight weeks before she could be admitted.

If Mrs. M had been a patient with money, or a patient with insurance, or a patient with Medicaid, I feel certain she would have been taken immediately. Patients who have severe, unremitting angina, so-called "crescendo angina," who have been shown to have severe blockage of their coronary arteries are, in my opinion, candidates for immediate surgery when they have failed to respond to maximum medications.

However, in Mrs. M's case, there did not seem to be much else we could do. She was sent home from Pueblo and appeared again the next day at our hospital with severe chest pain. She was admitted for a third time to our hospital. Initially, she seemed to be doing well. However, on her second day in the hospital she began to have more severe chest pain, which developed into a rather extensive myocardial infarction. In addition, her heart did not seem to be pumping as well as it should and some fluid began to build up in her lungs. University Hospital was contacted but, unfortunately, it was a weekend and no-one seemed able to authorize Mrs. M's transfer to the hospital. Finally, after the weekend was over, I was able to contact a cardiac surgeon who agreed to see Mrs. M and she was sent to University Hospital by ambulance with one of our coronary care nurses in attendance.

Ironically, the coronary care nurse was berated by University Hospital nurses when she arrived for "not sending up this patient sooner, when something could be done." I was contacted a few days later by the cardiac surgeon, who was quite apologetic about Mrs. M. Her heart had continued to develop cardiac failure. She had to go into emer-

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CMS Building Investment Program

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gency cardiac surgery and died intraoperatively.

I have since talked with the cardiac surgeon, the cardiologist in Pueblo, and gone over the case myself. All three of us have wondered the same thing: could Mrs. M have been saved had she been treated sooner, and not put off because the University Hospital had already had too many indigent patients that month?

I have been concerned for some time about the care of the medically indigent in Colorado, particularly because I'm a rural physician, without immediate access to certain "amenities" of modern medicine such as cardiac specialists. I have been concerned because many of us, including myself and the cardiologist in Pueblo, are willing to treat medically indigent patients free of charge. Yet the University Hospital, which receives most of the money allocated for indigent patients, is unable to accept patients whom I, as a rural physician with limited resources, cannot treat. I recognize the University Hospital's point of view—they have a budget to which they must keep—but this does not help people like Mrs. M.

What has happened in the state of Colorado is the creation of a two-tiered medical system. This is the new medicine that I as a physician and patients as consumers must deal with. The two-tiered medical system is very simple. If you can afford good medicine because you are rich or because you can afford to pay insurance premiums, you can afford the current quality of care that medical technology provides. If, however, you are medically indigent—or even if you have Medicaid, but budget cuts have prohibited certain types of procedures from being done for Medicaid patients—then you can only take what limited services the system can afford to offer you at that time. In some cases, as in that of Mrs. M, this may mean your demise.

An article by Gregory E. Pence in a December issue of the *Wall Street Journal* addressed this problem by saying, "Liberals want to subsidize medical care for the medically unfortunate, and my compassion agrees with him; the healthy and wealthy should subsidize the sick and poor. Conservatives argue that this can not go on forever; there are too many people, too many possible medical services, too many entitled and not enough obligated. Again, I agree; moreover, if the system does collapse, I can see that the poor and sick will be hurt the most." Mr. Pence's comments and Mrs. M's case raise difficult moral questions about our new medicine and our sociopolitical system. I don't have any answers to those questions. My dilemma is how to practice medicine effectively in such a climate.

One of my favorite movies used to be the original film version of "M*A*S*H." In a scene in which Hawkeye Pierce is doing an operation, he turns to a physician colleague and says, "Is this an officer or an enlisted man?" The answer is "An enlisted man," and Hawkeye responds, "Then take bigger stitches." After Mrs. M's case, and given the reality of two-tiered medicine in Colorado, I don't think I will be able to laugh at that part of the movie again.

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Minutes of the Annual Meeting

of the CMS House of Delegates September 20-22, 1984 Held at Vail, Colorado

Organizational

• Elected Richert Quinn, of Weld County Medical Society, to the office of President-elect, 1984-85.

• Elected the following physician members to the Board of Directors:

Robert Hartley, Weld, to a 2-year term to fill the unexpired term of Richert Quinn.

Grant Steffen, Arapahoe, to a 4-year term.

James Kurowski, Denver, to a 4-year term.

Marlin Weaver, Denver, to a 1-year term to fill the unexpired term of Jack Klapper.

Gerald Reilly, Pueblo, to a 4-year term.

H.G. Butler, III, LaPlata, to a 4-year term.

James Delaney, Aurora-Adams, to a 3-year term to fill the unexpired term of Robert O'Dell.

• Elected the following members to three-year terms on the Judicial Council:

James L. Karel, Denver, District 1

Jack L. Mackey, Sterling, District 4

Alan C. Stormo, Boulder, District 5

• Elected the following members to the Grievance Committee:

Lorence T. Kircher, El Paso

Richard Baisel, Aurora-Adams

Herman E. Doyle, Clear Creek Valley

• Elected the following members to two-year terms on as AMA delegates.

Kenneth A. Platt, Westminster, AMA Delegate

Robert A. O'Dell, Aurora, AMA Alternate Delegate.

• Elected William E. Lloyd, Colorado Springs, as Speaker of the House.

• Elected Ronald E. Tegtmeier, Arvada, Vice Speaker of the House.

• Approved the progress report of the Board of Directors.

• Approved the reports of the Building Committee and Ad Hoc Committee to Investigate the Building Project.

• Approved the following recommendations regarding the building project:

"1. That a limited partnership be formed with CMS as the *General Partner and that all members of the CMS be urged to become limited partners voluntarily.

(*Subsequently the Board of Directors approved CMS participation as a Limited Partner.)

2. That Kirk Douglas be hired as the Managing General Partner.

3. That this transaction be accomplished with these principles in mind:

A. All debts owed by the Society, including bonds, be paid in a fair and equitable manner. This payment may include rollover of bonds into land ownership and/or limited partner-ownership in the new building, extended buy-out periods at reduced interest rates, or a cash settlement.

B. The limited partnership be structured in such a manner so that it is a good tax shelter investment, using rent guarantees, rollovers as mentioned above, etc. as needed.

C. This should be accomplished by December 31, 1984.

D. CMS should receive equity interest for its investments *if* the transaction permits.

4. That should the partnership fail for lack of investors, then the Board of Directors proceed to option three, a long-term negotiated resolution of our indebtedness or a dues increase.

5. That the President, W. Gerald Rainer, and the Board of Directors make this their number one priority since the salvation of the Colorado Medical Society depends on a prompt resolution of this problem."

• Approved the progress report of the Member Insurance Benefit Committee and authorized the development of COMED, a health and major medical trust.

• Approved the administrative staff report.

• Approved the progress reports of the Grievance Committee and Judicial Council.

• Approved the report of the AMA delegation.

• Approved section 4 of the progress report of the Organizational Study Committee and approved filing of sections 1-3 and 5-9.

• Approved the filing of the reports of the President and President-elect.

• Adopted a resolution that a new subsection, "Dues Exempt Members", be added to the bylaws, chapter XII, as follows: "Members in the following categories will be exempt from paying dues: 1. Financial hardship or disability as determined by the Board of Directors; 2. Age 65-69 and retired from practice; 3. Age 70 regardless of retirement; 4. honorary members; 5. Dues paying member of CMS for 35 years." And, that Chapter I, membership, be amended to reflect the changes. (HB/Res 1)

• Adopted a resolution that the representative on the Board of Directors and the Nominating Committee be selected to represent both the Clear Creek Valley Medical Society and

the Mt. Evans Medical Society, that Mt. Evans be included in District II, and that the bylaws be so amended (HB/Res 2)

• Adopted a substitute resolution that the Speaker of the House be elected for two year terms and the Vice Speaker for a one-year term and that they serve on the Board of Directors as non-voting members. (HB/Res 3)

• Adopted a substitute resolution that the Hospital Medical Section budget be prepared by the CMS staff annually and included in the CMS budget until such time that a self-supporting section dues structure is appropriate. (HB/HMS/Res-1)

• Adopted an amended resolution that the Medical Staff Section meet the day prior to both the CMS Interim and Annual Meetings and that the resolutions approved at these meetings be treated in the same manner as other late resolutions. (HB/HMS/Res-2)

Legislation

• Approved the progress report and addenda of the Council on Legislation.

• Approved the progress report and supplemental report of COMPAC.

Public Health

• Approved the progress report of the Council on Public Health.

• Adopted a resolution that CMS recommend educational programs on the risks in riding horses and methods to minimize that; that CMS promote the use of protective headgear for riding activities and that all organized equestrian activities be urged to required that protective headgear be worn during these activities. (HB/Res-4)

• Adopted a resolution that CMS, in cooperation with bicycling organizations, manufacturers and other related groups, develop programs to promote the use of protective headgear for bicycling and that CMS urge the adoption of rules requiring the wearing of protective headgear at all organized bicycling events. (HB/Res-5)

• Adopted an amended resolution that CMS actively encourage legislation which limits or prohibits smoking in public areas in order to reduce passive smoke inhalation by nonsmokers and that CMS endeavor to provide expert testimony in support of such legislation. (HB/Res-9)

• Adopted a resolution that CMS initiate lobbying efforts to see that federal standards are developed to encourage compliance as soon as possible with regard to the health concerns, in particular sanitation facilities, of migrant farm workers in Colorado. (HB/Res-16)

• Adopted a resolution, in a joint statement with the Department of Health and the Colorado Hospital Association, that smoking be eliminated from all health facilities in Colorado. (HB/Res-17)

Professional Relations and Medical Service

•Approved the progress report of the Council on Professional Relations and Medical Service.

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• Adopted an amended resolution that CMS declare that chelation therapy for arteriosclerosis constitutes "unprofessional, inappropriate and potentially dangerous use of the drug and suggests that its advertisement and use in Colorado violates the Medical Practice Act." (Unfinished Business—2)

• Adopted an amended resolution that CMS support the AMA in the request that the AMA Commissioners to the JCAH "work for restoring the hospital's obligation to provide individual copies of medical staff bylaws, rules and regulations and policies to medical staff members and applicants *upon request*" and communicate this policy to all Colorado hospitals and the Colorado Hospital Association. (HB/HMS/Res-8)

Adopted the following resolutions on a consent calendar:

• A resolution that CMS "go on record that the hospital governing board bylaws not contain provisions whereby the hospital corporate board or administration could unilaterally amend the medical staff bylaws, or its rules and regulations; that CMS strongly support the efforts of the AMA Commissioners to the Joint Commission on Accreditation of Hospitals to incorporate this into the JCAH Standards; and that CMS advise all medical staffs in Colorado of this policy." (HB/HMS/Res-7)

• A resolution that CMS support as policy that "1) the medical staff bylaws, rules and regulations shall be initiated and adopted by the medical staff and shall establish a framework for self-government; 2) the medical staff shall govern itself by these bylaws, rules and regulations which shall: a) by reviewed and revised as necessary to reflect current medical staff practices; b) define the Executive Committee of the medical staff whose members are selected in accordance with criteria and standards established by the medical staff; and 3) the medical staff shall have authority to approve or disapprove all amendments to medical staff bylaws, rules and regulations; and that CNS support the AMA in its efforts to direct its commissioners to the JCAH to have these statements incorporated in the JCAH standards." (HB/HMS/Res-9)

• A resolution that CMS support the American Medical Association in urging its commissioners to the JCAH "to work for inclusion in its standards of the policy that medical staff bylaws not contain language stating that clinical privileges of contract physicians will automatically be terminated if their medical contract terminates." (HB/HMS/Res-10)

Socio-Economics

• Approved the progress report and additional report of the Council on Socio-Economics.

• Adopted an amended resolution to encourage all Colorado physicians to voluntarily freeze their fees for one year "while recognizing that physician fees comprise only 20 percent of overall health care costs and that any effective solution will require similar efforts on the part of all providers." The resolution also recommends that the Council on Socio-Economics develop a comprehensive study on cost containment. (Unfinished Business—3)

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• Adopted a resolution that CMS seek enactment of legislation that establishes a medically indigent program incorporating the following features:

"1. Formalization of a regionalized program which would designate certain institutions as MI care centers, either primary or referral, and direct funds to these hospitals.

2. Incorporation of a mechanism by which other hospitals in the state are required to contribute in cash or services to the overall MI program in order to even out the burden of cost shifting.

3. Enabling legislation to permit multi-jurisdictional regions the taxing authority to finance needed health delivery systems.

4. Expansion of the state Medicaid program to include the medically needy, targeted toward a small discrete population of children and pregnant women, to enable leveraging federal dollars with available state funds.

5. Includes provision for review by the CFMC, the state PRO, including concurrent hospital review, second opinion and preadmission certification.

6. Establishes a tax on cigarettes and alcohol sold in Colorado, with the revenues generated to be specifically designated for the MI program.

7. (Amended) Promotes the concept that medically indigent funds should be distributed proportionate to the documented medically indigent care rendered in various sections of the state."

8. Insures that any provision for cost sharing does not detrimentally affect the recipient's access to services.

9. Includes provisions for physician reimbursement.

10. Specifies separation of funding for medically indigent services from funding for medical research and education.(HB/Res-7)

• Adopted a resolution that CMS develop detailed recommendations for a pilot Medicaid program of prepaid capitated care, that this program be accomplished, if possible, without additional legislation and that a segment of metro Denver be targeted, by bid, for implementation of this pilot program. (HB/Res-8)

• Adopted an amended substitute resolution that COPIC increase its efforts to explain its rates, educate members regarding its financial status and management programs, and publicize the findings of recent audits and studies of COPIC by the State Insurance Commission. (HB/Res 14-A)

• Adopted an amended resolution that the Special Committee for Negotiations be dissolved and reconvened on ad ad hoc basis when necessary. (HB/Res-15)

Adopted the following resolutions on a consent calendar:

• A resolution that CMS inform its membership and the public about mandatory second opinion programs. (HB/HMS/Res-4)

• A resolution that CMS survey its membership regarding physicians' efforts toward health care cost containment; use this and other data to formulate a health care cost containment program for Colorado physicians; and develop an organized public information program "to improve confidence in the profession and enhance the physician image as an active participant in the solution of this problem (of health care cost containment)." (HB/Res-10)

Professional Education

• Approved the progress report of the Council on Professional Education with the following recommendations: the establishment of a library of video and audio tapes for the use of CMS members; continued emphasis on contemporary issues affecting medicine as the main thrust of the Scientific Program at the Annual Meeting; and an expression of appreciation to Dr. Patrick G. Moran "for his outstanding contributions to this (Reference) Committee for the past three years."

• Adopted a resolution that the CMS bylaws incorporate the following CME mission statement: "The CMS seeks continually to develop CME programs and to improve the quality of continuing medical education for the physicians of Colorado through the Society's educational programs and activities." (HB/Res 13)

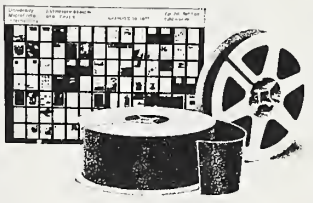
Foundation

• Approved the progress report of the Colorado Foundation for Medical Care.

• Adopted a resolution that the CMS work to ensure that hospital evaluation of physician performance resulting from DRG physician profiling be through an appropriate committee of the hospital medical staff which will have access to the raw data and will participate in the development of the data system. (HB/HMS/Res 5)

• Adopted a substitute resolution that CFMC review the activities of DRG review, denials and appeal for each Colorado hospital by region and hospital size and submit a report at the 1985 Interim Meeting. (HB/HMS/Res 14A)

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Delegate Attendance—1984 Annual Meeting

District I—19 Delegates

Larimer—8 Delegates

*(D) Elo, Dennis R. (1-2)
*(A) Murray, Garvin (1-2)
(D) Standard, Peter J. (1-2)
(D) Thorson, Steven J. (1-2)
(D) Kasenberg, Thomas P. (1-2)
(D) Merkel, Lawrence A. (1)
*(A) Codd, Richard L. (2)
(D) Preble, Parker E. (2)

Morgan—1 Delegate

(A) Mellinger, William (1-2)

Northeast Colorado—2 Delegates

(D) Beard, Charles A. (1-2)
(D) Clark, Curtis C. (1-2)

Washington-Yuma—1 Delegate

None Present

Weld—7 Delegates

(A) Humphries, William C. (1)
(A) Peterson, James H. (2)
(D) Hartley, Robert D. (1-2)
(D) Kahn, Robert J. (1-2)
(D) Baldwin, Thomas E. (1-2)
(D) Clark, Ronald D. (1-2)
(D) Humphries, Patricia B. (1-2)
*(A) Crews, Jerry R. (1-2)

District II—122 Delegates

Aurora-Adams County—10

*(A) Buckley, Jerome (1-2)
(D) Heaton, Angeline (1-2)
(D) Kitlowski, Noel P. (2)
(A) Battock, Dennis J. (1)
(D) Odekirk, Larry L. (1-2)
(D) Sherman, Eugene (1)
*(A) Rokicki, Robert R. (2)
(D) Delaney, James J. (1-2)
(D) Heaton, C. Edward (1-2)
(D) Hopple, Lynwood M. (1-2)
(D) Imatani, Raymond (1-2)
(D) Palmieri, Anthony (1-2)

Arapahoe—16 Delegates

(A) Lovejoy, Brent V. (1-2)
(D) Knize, David M. (1-2)
(D) Kreye, George M. (1-2)
(D) Paton, Bruce C. (1-2)
(D) Steines, William J. (1-2)
(D) Wood, John M. (2)
(D) Baker, Bruce B. (1-2)
(D) Bartee, Roy M. (1-2)
(D) Bartlett, Max D. (1-2)
(D) Freed, John H. (1-2)
(D) Miller, Meredith H. (1-2)
(D) Makowski, Anthony (2)
(A) Bigelow, Eugene V. (1-2)

Boulder County—11 Delegates

(D) Benson, Alan E. (1-2)
(D) Harley, Ned (2)
(D) Hickman, Gerald M. (2)
(D) Rubright, Mark W. (1-2)
(A) Lausterer, Jack (1-2)
(D) Smith, Darvin (1-2)
(D) Stein, Donald (1-2)
*(A) Glode, John E. (1-2)
(D) Bolles, Gene E. (2)

Clear Creek Valley—20 Delegates

(D) Campbell, Bernard E. (1-2)
(D) Doig, William L. (1-2)
*(A) Vacanti, John (2)
*(A) Henderson, Kenneth R. (2)
(D) Golbert, Thomas (1-2)
(D) Mann, James (1-2)
*(A) Summerer, Robert (2)
(D) Sadler, Dean (1-2)
(D) Tegtmeier, Ronald (1-2)
(D) Underwood, Larry D. (1-2)
(D) Yakely, M. Robert (1-2)
(D) Berg, Dalrie (1-2)
(D) Brundige, Richard L. (1-2)
(D) Cedars, Chester M. (1-2)
(D) Netz, Howard E. (1-2)
(D) Oppenheim, Walter H. (1-2)
(A) Conner, Wayne (1-2)
(D) Rosenberg, Alan L. (1-2)
(D) Silverberg, Stuart O. (1-2)
(D) Weston, Eugene L. (1-2)

Denver—60 Delegates

(D) Aikawa, Jerry K. (1-2)
*(A) DeLauro, John (2)
(D) Bailey, William C. (1-2)
(D) Bennett, Willis L. (1-2)
(D) Blaney, Loren F. (1-2)
(D) Boswick, John A., Jr. (2)
(D) Bramley, Howard F. (1-2)
(A) Bremers, Harold H. (1-2)
(D) Campbell, William A., III (2)
(D) Chilcoar, Donald (1-2)
(D) Cook, William R. (1-2)
(A) Mack, Robert P. (2)
(D) Hiatt, W. Stewart (1-2)
(D) Hoch, Peter (2)
(D) Humphries, Jesse H. (1-2)
(D) Jackson, Charles T. (1-2)
(D) Kail, Thomas J. (1-2)
(A) Lacher, John W. (2)
*(A) Christianson, Eleanor (2)
(D) Nelson, Nancy (1-2)
(D) Newman, Thomas H. (1-2)
(D) Parsons, Donald W. (1-2)
(D) Peck, Mordant E. (2)
(A) Safford, H.R., III (2)
(A) Shira, James E. (2)
*(A) Woodard, Donald (2)
(A) Hoehn, Robert (2)
(A) Hite, L. Carey, III (1-2)
(D) Sawyer, Kenneth C., Jr. (2)
(D) Sides, LeRoy J. (1-2)
*(A) Zbylski, Joseph (1-2)
(D) Stanfield, Clyde (1-2)
(D) Sullivan, Robert C. (1-2)
(D) Toll, Giles D. (1-2)
(D) Waldman, Lawrence S. (1-2)
(A) Abrams, Fredrick R. (2)
(D) Ballonoff, Larry B. (1-2)
(D) Butterfield, Donald G. (2)
(D) Carlson, H. Blair (1)
(A) Cole, Toby P. (2)
(A) Claassen, David W. (2)
(A) Howe, Patrick (2)
(A) Hutchison, David (2)
*(A) Ballinger, Carter (2)
(A) Casper, Edmund (2)
(D) Holman, Richard E. (1-2)
(D) Inkret, William, Jr. (1-2)
(D) Kelble, David L. (1-2)
(A) Kennedy, Timothy C. (2)
(D) Kosmicki, Patrick (2)
(D) Lightburn, John L. (2)
(D) Livingston, Wallace H. (1-2)
(D) Muftic, Michael (2)
(A) Merrick, Thomas A. (1-2)
(D) McCurdy, Robert (1-2)
(A) Walker, Louise D.C. (1-2)
(A) Mueller, John F. (2)
*(A) Coleman, Thomas (1-2)
(D) Schemmel, Janet (1-2)
(D) Sigdestad, Joel B. (1-2)
(A) Odom, J. Thomas (2)
(D) Smyth, Charley J. (2)
*(A) Klapper, Jack A. (1-2)

UCMC Student—4 Delegates

(D) Ardell, Lynda (1-2)
(D) Zartman, Gary M. (1-2)
(D) Papenfus, Gary M. (1-2)
(D) West, Margie L. (1-2)

Mount Evans—1 Delegate

None Present

District III—21 Delegates

Eastern Colorado—1 Delegate

None Present

El Paso County—18 Delegates

(A) Lewis, Ted T. (1-2)
(A) Gifford, Marilyn J. (1-2)
(D) Cooper, Jack (1-2)
(D) Cunningham, Leon (1-2)
(D) Hanson, J.R. (1-2)
(D) Miller, Floyd J. (1-2)
(D) Nathan, Robert A. (1)
(A) Pick, Melvin M. (2)
*(A) Wahl, Ray (2)
(A) Spaulding, Duane R. (1-2)
(D) Bengfort, John L. (2)
(D) Burton, Richard M. (1-2)
(D) Dawson, Dwight C. (1-2)
(D) Genrich, John H. (1-2)
(D) King, Otis J. (1-2)
(D) Messner, Milo L. (1-2)
(D) Seybold, William (2)
(D) Woodworth, W. H. (1-2)

Intermountain—1 Delegate

None Present

Lake County—1 Delegate

None Present

District 1V—19 Delegates

Chaffee County—1 Delegate

None Present

Fremont County—2 Delegates

(D) Gamache, Peter (1-2)
(A) Grabow, Henry C. (1-2)

Huerfano County—1 Delegate

None Present

Las Animas County—1 Delegate

None Present

Otero County—2 Delegates

*(A) Gay, Kent E. (1-2)
*(A) Stutzman, Howard (2)

Pueblo County—9 Delegates

*(A) Salerno, Charles (2)
(D) Crosson, David L. (1-2)
(D) Phelps, Harvey (1-2)
*(A) Chimento, James (1-2)
(D) Bedard, Charles H. (2)
*(A) Drake, Robert L. (1-2)
(A) Lawrence, Richard (1-2)
*(A) Mastro, Gilbert E. (1-2)
(D) Reilly, Gerald (1-2)

San Luis Valley—2 Delegates

(D) MacLeod, William (12-)
(D) Schmidt, Edwin (1-2)

Southeastern Colorado—1 Delegate

*(A) Bermingham, Roger P. (1-2)

District V—18 Delegates

Delta County—1 Delegate

None Present

La Plata County 3—Delegates

(A) Butler, Harrison G., III (1-2)

Mesa County—6 Delegates

(D) Hartshorn, Denzel (1-2)
(D) Huskey, Harlan (1-2)
(D) Moran, Patrick G. (1-2)
(D) Painter, M. Ray (1-2)
*(A) Phillips, Michael S. (1-2)
*(A) Hanna, Robert (1-2)

Montelores County—1 Delegate

(D) Howe, Gerald E. (1-2)

Curecanti—2 Delegates

(D) Canfield, Thomas M. (1-2)

Mount Sopris County—3 Delegates

(D) Jacobs, Mary Jo (1-2)
(A) Kirk, Rodney E. (2)

Northwestern Colorado—2 Delegates

(D) France, David W. (1-2)

Medical Staff Section—1 Delegate

(D) Schell, Roxie A. (1-2)

CMS Advocates Smoke-Free Air

CMS, Health Department and Health Association Issue No-Smoking Statement

On June 1, 1984, the CMS Board of Directors adopted a joint statement with the Colorado Hospital Association and the Colorado Department of Health regarding smoking in health care facilities. The statement was approved by the House of Delegates at the CMS Annual Meeting September 20-22. The following is the text of the adopted resolution:

WHEREAS, it is incumbent upon the Colorado Medical Society to continue any and all efforts to reduce the hazards of smoking; therefore, be it

RESOLVED, that the Colorado Medical Society adopts the statement below prepared jointly by the Colorado Medical Society, the Colorado Hospital Association and the Colorado Department of Health.

Because smoking is the single most preventable cause of illness and early death, health care providers have a responsibility to take a leadership role to reduce smoking, to encourage non-smoking, and to protect the rights of the non-smokers.

We recognize our role as exemplars in influencing the smoking behavior of the general public, and our responsibility in educating the community at large regarding the health hazards of smoking.

We are particularly concerned with the dangers of smoking, and address this subject as a high priority issue.

Exposure to cigarette smoke not only adversely affects the health of the smoker but increases the health risk and discomfort of patients who are already at risk for medical complications. Therefore, it is incumbent upon health care professionals to eliminate smoking in all health facilities.

Because we, as health care providers, professionals and educators, are in a unique position to support the aims of all smoking-reduction activities, we unite our voices in a joint statement to recommend that smoking ultimately be eliminated from all health facilities in the state of Colorado.

Editor's Note: CMS physicians have become actively involved in the effort to educate the public about the dangers of smoking and to reduce the risk to non-smokers from the effects of passive smoking. Following are two non-smoking resolutions passed by the House of Delegates, plus a brief report on a recent study on the effects of passive smoke inhalation.

CMS Passes Resolution Against Public Smoking

The CMS House of Delegates adopted the following resolution, introduced by the Larimer County Medical Society, regarding smoking in public places and potential dangers caused by passive smoke inhalation:

WHEREAS, the health hazards of smoking are well-documented and the impact of smoking on the general health of American citizens is substantial, and

WHEREAS, the nonsmoker has a right to a smoke-free environment, and

WHEREAS, certain local and state governments have passed legislation to prohibit smoking in enclosed spaces; therefore, be it

RESOLVED, that the Colorado Medical Society actively encourages legislation which limits or prohibits smoking in circumstances which result in passive smoke inhalation by nonsmokers; and be it further

RESOLVED, that the Colorado Medical Society will endeavor to provide expert testimony in support of such legislation to those governmental entities considering enactment of such laws.

New Study on Effects of Passive Smoke Inhalation

A recent study published in the *New England Journal of Medicine* (September 27, p. 828) proposed restrictions on contact between smokers and non-smokers because of possible effects from passive smoke inhalation.

According to the study, directed by Dr. Shigeru Matsukura of Kyoto School of Medicine, a non-smoker whose family members smoke more than two packs of cigarettes a day actually inhales the equivalent of one or even two cigarettes.

The study was conducted on 472 non-smokers. The researchers took urine samples and analyzed the amount of continine they contained. Cotinine is left when nicotine is broken down in the body, and experts believe it provides an accurate estimate of how much smoke has been consumed.

The urinary continine levels were highest among non-smokers whose family members smoked more than 40 cigarettes a day.

If all CMS members invested their '84 and '85 IRA funds (2,000) in the CMS Building Investment Program, CMS would successfully pay off its nine million dollar loan.

A Proposal To Ban Cigarette Advertising

Editorial Note: The following article was written by Larry White, JD, and is reprinted from the **American Council on Science and Health News and Views,** *Volume 5, Number 4, 1984.*

Cigarettes are the leading cause of preventable disease in the United States, are addictive and have no safe minimum exposure level. They are also the most advertised product in our society. It is a rare urban dweller who can pass a day without seeing several cigarettes ads in one form or another.

According to the Federal Trade Commission, two of the five top magazine advertisers are cigarette companies; R.J. Reynolds is the single largest magazine advertiser. Cigarettes are the most heavily advertised product in American newspapers. Almost half the billboards in the United States carry cigarette ads.

There have been numerous actions to control cigarette advertising in the United States. The FTC, which has the authority to regulate false and misleading advertising, forced cigarette manufacturers to withdraw misleading claims 25 times between 1938 and 1968. Congress required cigarette manufacturers to put health warning labels on cigarette packages in 1965 and, in 1970, made the warning a little stronger and ordered it to be put on advertisements as well. In 1970, Congress banned cigarette advertising on radio and television.

Cigarette ads still abound in the print media, however, and one of their major functions is to subvert the health warning. The smokers depicted in the cigarette advertisements are quite healthy and active; they obviously are not suffering from lung cancer, heart disease or emphysema.

The warning label that is presently required on all cigarette packages and advertising is simply not noticed or read by the vast majority of consumers, and the FTC staff has concluded that "a substantial majority of the public remains uninformed about the hazards of smoking."

Congress is presently considering new warning labels that probably would be somewhat more effective in alerting consumers to the dangers of smoking. But whatever new warning is mandated, it will be put on advertisements for cigarettes, which will undoubtedly detract from its impact.

A Major Social Problem

More than 53 million Americans continue to smoke and large numbers of young people take up the habit daily. Clearly, cigarette smoking is a major social problem that requires far-reaching solutions.

One approach would be to ban the sale of cigarettes. It is within the power of Congress to ban the interstate traffic in cigarettes. This is, of course, politically impossible and of questionable wisdom as our country's experience with Prohibition has shown.

A more sensible approach would be to ban the promotion of cigarettes. Although this has already been done in the broadcast media, many people assume that it would be unconstitutional to ban cigarette advertising in the print media. This view had some validity a few years ago, but recent Supreme Court decisions indicate that a total ban on cigarette promotion might indeed withstand the court's scrutiny. Although a ban on cigarette promotion is not now politically feasible, it may be that in a few years changing attitudes about smoking and the growing awareness of its dangers will make such a ban possible.

The First Amendment

If there were a constitutional objection to a law banning cigarette promotion, it would be found in the language of the First Amendment, which states, "Congress shall make no law. . . abridging the freedom of speech." These ten words, part of a larger guarantee of religious liberty, freedom of the press and the rights of assembly, are the perennial subject of lawyerly debate.

Constitutional protection has traditionally been concerned largely with expressions of political and social ideas that relate to matters of public interest. Few theorists have argued that all speech must be free from regulation. Obscenity may be banned and words that incite a mob to violence may be outlawed. The government may regulate, within reason, the time, place and manner of speech. The citizen's right to speak out on political matters is inviolate, but he cannot speak in the middle of a busy street. Commercial speech, including advertising, was historically not considered to be covered by the First Amendment.

When the Federal Trade Commission was given the right to deal with unfair and deceptive business practices in 1938, deceptive advertising became a prime target. In 1942, the Supreme Court confirmed the notion that commercial speech is not protected by the First Amendment. When the ban on broadcast advertising of cigarettes was challenged on First Amendment grounds (by the broadcasters, not the tobacco industry) a U.S. district court ruled that Congress had the power to prohibit the advertising of cigarettes in any medium.

In this were still the law, there would be no doubt that Congress could ban cigarette promotion. However, in 1976, the Supreme Court ruled that purely commercial speech does enjoy some First Amendment protection. This case, Virginia Board of Pharmacy vs. Vir-

ginia Citizens Consumer Council, 425 U.S. 748 (1976), opened a constitutional can of worms. Since then, the Supreme Court has struggled to deal with the problems inherent in extending the First Amendment where it had never applied before —advertising.

In the Virginia Pharmacy case, the Supreme Court struck down a state law that made it illegal for druggists to advertise the prices of prescription drugs. The public needed this kind of information, the court said, and had a First Amendment right to receive it; the interest of the state in preserving the professionalism of pharmacists could not justify the law. Unfortunately, the court seemed to go beyond the facts of the case at issue and made some very sweeping and misleading pronouncements.

Despite the strong language of this case, there were indications that the court did not intend that commercial speech would be treated with the same deference as non-commercial speech. Some speech just seemed like it shouldn't be protected for a variety of practical reasons and the court had to pinch some of the bloom off Virginia Pharmacy in order to uphold laws that restricted commercial speech.

In a 1978 Ohio case, the Supreme Court was presented with the argument that the First Amendment should protect a lawyer who personally solicited clients in a classic ambulance-chasing situation. Although there was nothing deceptive or misleading about the lawyer's "speech," the court held that the state had the right to forbid this kind of activity. The next year the court decided that it was permissible for the state of Texas to forbid optometrists from practicing their profession under a trade name. Trade names did not convey any useful information, the majority of the court reasoned, and it was the informational function of commercial speech which brought it the First Amendment protection.

A number of legal commentators criticized the court for deciding cases simply on their individual merits and not establishing a principled body of law regarding commercial free speech so that legislatures and Congress could predict with some degree of accuracy whether a law would be found valid or not. The court was also given poor marks for interfering in economic regulation under the guise of protecting speech. By 1980, the court began to recognize the problems it had created and to attempt to bring order out of what appeared to be chaos.

In 1980, the court struck down a New York state regulation that forbade a utility from sending out notices promoting the use of electricity. Finally, with this case, the court systematized the rules regarding commercial free speech. The constitutional analysis provided in this case has withstood the test of subsequent cases and emerged as a guide for determining whether a law regulating commercial speech is constitutional.

The court finally made it clear that commercial speech enjoyed a kind of "second class" protection under the First Amendment. Any false or misleading speech could be banned, since the constitution does not prevent the government from "insuring that the stream of commercial information flows cleanly as well as freely." Even more important, the court recognized that some commercial speech could be banned though it concerned entirely lawful conduct and was not misleading.

According to this ruling, if the government can show an important reason to regulate a particular type of commercial speech, and if the regulation in question actually advances the asserted governmental interest, and if the regulation is not more extensive than necessary, the government's power will not be limited by the First Amendment.

Insofar as such advertising is misleading, it can be banned without further analysis. Those who know the facts about smoking might reasonably argue that all cigarette promotion is misleading, since its purpose is to induce people to buy a product that is both harmful and addictive. However, many people do not yet understand the full dangers of smoking and the idea that cigarette advertising is intrinsically misleading may not be accepted by the courts in the near future.

But a law that banned cigarette



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advertising would most likely be constitutional even if such advertising were not found to be intrinsically misleading. The government's justification for such a law would be to reduce the incidence of smoking-related diseases by reducing the number of smokers. This is certainly an important state interest that would pass constitutional muster.

Further, the total ban on promotion of cigarettes would not be more extensive than necessary. Indeed, only a total ban would be effective. Foreign experience, as well as American experience with the ban on cigarette advertising in the broadcast media, shows that tobacco companies will transfer their vast promotional budgets to whatever type of promotion is allowed. In Italy, where there is a ban on cigarette advertising in the print media, but not on other types of promotion, the tobacco companies sponsor sports and artistic events and have found many other ways to promote cigarettes. Not surprisingly, consumption has not declined since the advertising ban went into effect. Norway, by contrast, has a strict ban on all forms of cigarette promotion. Since the ban was instituted in 1975 there has been a significant drop in cigarette consumption, according to the World Health Organization.

Behind the purely legal questions involving commercial free speech are important ethical and political principles. A sense of justice no doubt led to the reasoning that laws which keep useful information from the public are unconstitutional.

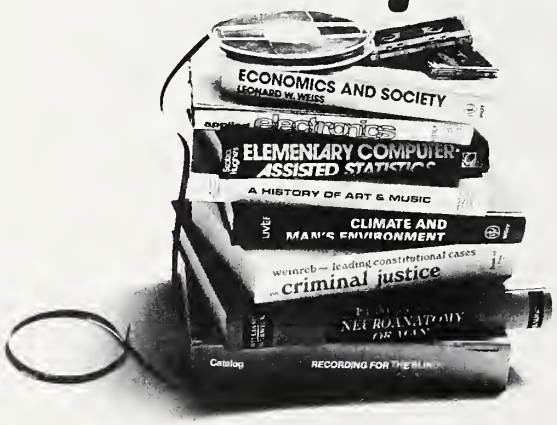
In the context of a proposed ban on cigarette promotion, this concern takes on an unusual twist. Eliminating cigarette promotion would reduce the flow of information hardly at all. Almost all cigarette advertising is merely the association of smoking with an attractive image and its loss would not affect consumers' abilities to choose intelligently. It is expected that any ban would allow advertising at point of sale, and it is there that any useful information, such as tar and nicotine levels, as well as price, could be displayed.

Allowing cigarette advertising, as we do now, actually has the effect of reducing the flow of information to the public. The greatest under-reported health story of the century is the epidemic of cancer, heart disease, lung disease and other consequences of smoking. This story has not been reported as it should have been because tobacco advertising is allowed.

Cigarette advertising is a major source of revenue for many, if not most, newspapers and magazines. Editors are fearful of publishing the truth about smoking because they know that such stories will provoke the wrath of the tobacco companies. The loss of cigarette advertising revenues would be serious for the many publications that have become dependent on them. But even more serious is the human and social cost in death and disease that is a consequence of the suppression of the truth about the hazards of smoking.

The First Amendment is one of the greatest achievements of our free society. But it was not meant to be and should not be used as a refuge for an industry which is responsible for the premature deaths of 350,000 Americans annually.

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A Positive Health Strategy for the Office Waiting Room

by John W. Richards, Jr., MD

Editor's Note: The following article is reprinted with permission from the* New York State Journal of Medicine, *December, 1983 (copyright 1983, Medical Society of the State of New York). The article is taken from a special issue of the journal entitled "The World Cigarette Pandemic." More than 7,000 copies of the journal have been distributed since its publication last year and a second printing of the journal is planned. The issue includes articles on the medical, political and economic aspects of smoking, focusing on problems within the U.S. and abroad. Physicians and medical students interested in obtaining a copy of this special issue should write to the editor, Alan Blum, MD,* New York State Journal of Medicine, *PO Box 5404, Lake Success, New York, 11042.

Another edition of the* New York Journal of Medicine *of interest to physicians, medical students and hospital administrators is the July issue, which reviews the controversial offshore medical schools. Those interested in this issue should write to Dr. Blum at the above address.

In 1979 the American Medical Association (AMA) congratulated a group of magazine publishers for their refusal to accept tobacco-product advertising. The AMA was unstinting in its praise: "In view of the overwhelming evidence against smoking, your policy of refusing to accept tobacco advertising can only be construed as an unselfish act. America's physicians applaud your action."

The following year the Congress of Delegates of the American Academy of Family Physicians (AAFP) approved a resolution to "commend publications which have refused to accept tobacco advertising and to circulate to its members a list of these publications."

These actions came at the request of physicians in the AMA and the AAFP who also belong to DOC (Doctors Ought to Care, c/o Thomas Houston, MD, Floyd Medical Center, 304 Turner-McCall Blvd., Rome GA 30161). DOC had compiled a list of such magazines and had explored attitudes on the part of physicians and publishers on the subject of cigarette advertising in magazines placed in the office waiting room.

In 1979 DOC conducted a mail questionnaire survey of members of the South Carolina Medical Association, to examine their knowledge of smoking-related illness and patient education.

With regard to the various risk factors for premature deaths, most of the 156 respondents were aware that cigarette smoking was responsible for the highest number of premature deaths in the United States. It was also the one factor for which physicians felt the need for more patient education materials.

Although 70 percent of the respondents felt that the waiting room is a good place to learn about health (and 60 percent felt that patients thought so, too), 70 of 145 respondents to one question admitted spending nothing on health education materials for the waiting room; only 18 physicians claimed to spend more than $60 a year on such material, preferring to accept free pamphlets from the voluntary health agencies and governments. In contrast, more than half (83) subscribed to six or more commercial magazines for the waiting room, and two thirds of the respondents spent $50 or more each year on such subscriptions. The most frequently subscribed-to magazines were *Time* (49), *Newsweek* (47), *Sports Illustrated* (33), *Better Homes & Gardens* (32), *People* (28), *US News & World Report* (27) and *Ladies Home Journal* (27). Only three of the top ten magazines subscribed to by physicians for their waiting rooms did not contain cigarette advertising: *National Geographic* (25), *Good Housekeeping* (22) and *Reader's Digest* (21). Intrigued by the DOC survey, one physician reported 390 pages of cigarette advertising in the magazines in his waiting room!

The most advertised product in the magazines most subscribed to by physicians for the patient waiting area is cigarettes. In magazines such as *Time* and *Newsweek,* cigarette advertising comprises between 15 percent to 80 percent of total color advertising for a given issue (except for the June 6, 1983 issue of *Newsweek,* which contained a story on non-smokers' rights; *Newsweek,* not the tobacco companies, pulled the cigarette ads.) Although they have published cover stories on AIDS, Legionnaire's disease, Tylenol and toxic shock syndrome, these magazines have not carried a cover story on smoking since 1970—when the bulk of cigarette advertising switched into the printed media. In 1977, in an article on carcinogens, *Newsweek* listed tobacco as number eight (arsenic was listed as number one; the list was in alphabetical order). Each year, *Time* and *Newsweek* accept in excess of $30 million in cigarette advertising, or approximately 20 percent of total advertising income. *Time, Newsweek, Better Homes & Gardens* and other magazines buy mailing lists of physicians to offer reduced "professional courtesy" subscription discounts.

When questioned by physician-subscribers about the policy of accepting cigarette advertising, *Time* has sent form letters which say, "We respect your right to disagree with us." The publisher of *Better Homes & Gardens,* which has made a concerted effort to be portrayed as a health magazine (notwithstanding the 15 to 20 pages of cigarette advertising in each issue), has expressed his hope that "those people

who do not smoke will turn past the cigarette ads." *Newsweek* has perhaps the lengthiest stock reply:

We know that many of our readers object to the publication of cigarette and liquor advertisements. We feel, however, that if we were to accept some ads and reject others, we would be, in effect, endorsing products and making the very kind of editorial statement through our advertising columns that we so scrupulously avoid in our news copy. Therefore, we accept ads from the makers of all legal products, so long as these ads conform to the standards of good taste and ethical practice established by the Better Business Bureau and the Magazine Publishers Association.

We hope you realize, though, that our editorial department is completely independent from our advertising department, and our running ads from tobacco companies and distilleries has never prevented us from conscientiously reporting on the health hazards and social problems related to smoking and, for example, heart disease, ulcers and lung cancer. We examine the abuse of alcohol among teenagers, the dangers of mixing drugs and alcohol, and the link between drinking and birth defects. We think that through these reports we fulfill our responsibilities as an independent news source, whatever the content of the ads that appear in the magazine.

There are a few bright spots, most notably that of *Runner's World*, whose editor and publisher, Bob Anderson, has made a special appeal to physicians.

There's a serious problem sitting in your waiting room. It's magazines. Magazines filled with full-page advertisements promoting one of the most serious health problems in the world: cigarettes Just a glance through any one of hundreds of popular periodicals will indicate that they derive a major portion of their revenues from the thriving tobacco industry. And while your patients are sitting there waiting for you to help them improve their health, these high-powered ads are encouraging them to ruin it. Successfully, too. Because despite all the efforts to dampen America's voracious appetite for tobacco, the deadly weed is doing very well.

We'd like to make a modest suggestion. Subscribe to a publication that refuses to accept cigarette advertising. It's *Runner's World Magazine*. In *Runner's World*, you'll find the same national advertisers found in those other magazines, but you won't find one advertisement promoting poor health. In fact, nearly every advertisement, and absolutely every article, promotes good health, exercise, and proper diet. There are no advertisements for distilled spirits either. . .

On October 10, 1983, *The Saturday Evening Post* announced that effective with its March 1984 issue, it will no longer accept tobacco advertising. For a publication that had been fighting a tough battle for survival in recent years, the move suggests that publications that cultivate non-tobacco advertising revenue no longer must accept cigarette ads. The *Post's* publisher is Cory Ser-Vaas, MD.

Some physicians, such as Hunter Fry of Melbourne, Australia, prefer to call attention to cigarette ads by writing ridiculing slogans on the ads with a felt-tip pen as a means of making patients more aware of how the ads undermine health. Other physicians buy a rubber stamp or stickers that say "This advertisement is a rip-off." Others, such as Stephen Barrett of Allentown, PA, head of the Lehigh Valley Committee Against Health Fraud, fill out the blank subscription forms in the magazines with the statement, "It is immoral to accept cigarette advertising." He has yet to receive a reply.

The physician has a golden opportunity to enhance the healthful environment of the office by scrutinizing magazines for misleading and anti-health advertising. If 400,000 American physicians vowed not to let their office waiting rooms be vehicles for cigarette sales, this would contribute significantly to health promotion. Canceling subscriptions to such publications—informing the publisher for the reason—might set the ball rolling toward changes in publishing policy.

Following is the most recent listing of magazines that do not accept cigarette advertising.

W = weekly; M = monthly; BM = every other month.

General Interest

Consumer Reports—(M-$12) 256 Washington St., Mt. Vernon, NY 10550
The Futurist—(BM-$20) 4916 St. Elmo St., Bethesda, MD 20814
Good Housekeeping—(M-$12.97) 959 Eighth Ave., New York, NY 10019
Mother Jones—(M-$18) 625 Third St., San Francisco, CA 94107
The New Yorker—(W-$32) 25 W. 43rd. St., New York, NY 10036
Parents Magazine—(M-$7.95) 685 Third Ave., New York, NY 10017
Reader's Digest—(M-$12.93) Reader's Digest Rd., Pleasantville, NY 10570

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Travel

Adirondack Life—(BM-$10) 420 E. Genesee St., Syracuse, NY 13202
Arizona Highways—(M-$15) 2039 W. Lewis, Phoenix, AZ 85009
Missouri Life—(M-$15) 1205 University Ave., Columbia, MO 65201
National Geographic—(M-$15) 17th & M Streets, NW, Washington, DC 20036
Nevada Magazine—(BM-$7.95) 101 S. Fall St., Carson City, NEV 89410
Travel Holiday—(M-$9) Travel Bldg., 51 Atlantic Ave., Floral Pk, NY 11001
Vermont Life—(Q-$4) Vermont Development Dept., 61 Elm St., Montpelier, VT 05602
Yankee—(M-$14) Main St., Dublin, NY 03444

Sports

Bicycling—(9/yr.-$10) 35 E. Minor St., Emmaus, PA 18049
The Runner—(M-$15) One Park Avenue, New York, NY 10016
Runner's World—(M-$14.95) 1400 Stierlin Rd., Mountainview, CA 94043
Sail—(M-$21.75) PO Box 10219, Des Moines, IA 50380

Youth

Boy's Life—(M-$10.80) 1325 Walnut Hill La., Irving, TX 75062
Humpty Dumpty Magazine—(8/yr.-$11.95) 1100 Waterway Blvd., Indianapolis, IN 46206
Jack and Jill—(8/yr.-$11.95) 1100 Waterway Blvd., Indianapolis, IN 46206
Mad Magazine—(8/yrs.-$9.75/10 issues) 485 Madison Ave., New York, NY 10022
Ranger Rick (nature magazine)—(M-$9.50) National Wildlife Federation, 1412 16th St., N.W., Washington DC 20036
Sesame Street—(10/yr.-$6.95) 1 Lincoln Plaza, New York, NY 10022
Seventeen—(M-$11.95) 850 Third Avenue, New York, NY 10022

Avocations

American History Illustrated—(10/yr.-$16.95) Box 822, Harrisburg, PA 17105
British History Illustrated—(MB-$12) Cameron & Kolker Streets, Harrisburg, PA 17105
Collectibles Illustrated—(BM-$11.50) Main St., Dublin NH 03444
Crafts—(M-$15) PO Box 10103, Des Moines, IA 50347
Dance Magazine—(M-$22) 1180 Avenue of the Americas, New York, NY 10036
Fishing Facts—(M-$17.88) PO Box 609, Menomonee Falls, WI 53051-9984
Historic Preservation—(BM-$15) National Trust for Historic Preservation, 1785 Massachusetts Ave., Washington DC 20036
Horticulture—(M-$18) 300 Massachusetts Ave., Boston, MA 02115
Model Railroader—(M-$20) 1027 North Seventh St., Milwaukee, WI 53233
Modern Photography—(M-$7.98) PO Box 10785, Des Moines, IA 50349
Organic Gardening—(M-$12) 35 East Minor St., Emmaus, PA 18049
Personal Computing—(M-$18) 50 Essex St., Rochelle Park, NJ 07662
Popular Communications (ham radio)—(M-$12) 76 North Broadway, Hicksville, NY 11001
Popular Computing—(M-$12.97) PO Box 307, Martinsville, NJ 08836
Railfan & Railroad—(M-$17) PO Drawer 700, Newton, NJ 07860
Theatre Crafts—(9/yr.-$15.75) Suite 312, 250 W. 57th St., New York, NY 10017
Writer's Digest—(M-$18) 9933 Alliance Rd., Cincinnati, OH 45242

Science

Animal Kingdom—(BM-$7.95) 185th St. & Southern Blvd, New York, NY 10460
Audubon—(BM-$13) 950 3rd. Ave., New York, NY 10022
Natural History—(M-$15) Central Park West at 79th. St.,New York, NY 10024
Nutrition Action—(10/yr.-$10) Center for Science in the Public Interest, 1755 S St., NW, Washington, DC 20009
Scientific American—(M-$21) 415 Madison Ave., New York, NY 10017
Smithsonian—(M-$17) 900 Jefferson Dr., Washington, DC 20560
The Sciences—(10/yr.-$12.50) 2 East 63rd St., New York, NY 10021
Zoo News—(M-$8) PO Box 551, San Diego, CA 92112



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CALENDAR

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November 1984

1 **Neuropsychiatric Grand Rounds**—Pueblo, Colorado 1-3 p.m. APA-approved course for Category 1 credit, developed by Colorado State Hospital to examine the relationship of neurological and psychiatric disorders. Contact: James Scully, MD, 1600 W. 24th St., Colorado State Hospital, Pueblo, CO. Meeting to be held in Conference Room A. (303) 543-1170.

2 **Leukemia Society Annual Symposium**—Alameda Plaza Hotel, Wornell at Ward Parkway, Kansas City, Missouri. Credit: AMA Category 1, AAFP. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th and Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

2 **Annual Diabetes Symposium**—University of Kansas Medical Center, Kansas City, Kansas. Credit: AMA Cat. 1, AAFP, CNE. Contact: Jan Johnson, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

8–11 **Contemporary Facial Reconstructive Surgery**—Columbus, Ohio. Fees: $525 AAFPRS Member, $600 Non-AAFPRS Member; $300 Resident-in-Training; $100 Laboratory Sessions. Credit: 27.5 hours in Cat. 1. Contact: Center for Continuing Medical Education, A352 Starling-Loving Hall, 320 W. 10th Ave., Columbus, OH 43210. Presented by Ohio State University Medical Center, Rhodes Auditorium, 450 W. 10th Ave., Columbus, OH.

14 **Dementia: Dealing with Patient and Family Depression**—Kansas City, Kansas. Credit: 7 contact hours (0.7 CEUs) nursing education credit; 8 hours AMA Cat. 1; social worker and physical therapist credit pending. Fee: $30. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KA 66103. (913) 588-4480.

14–17 **XXXII Annual Convention of the Medical Society of the United States and Mexico**—Guadalajara, Mexico. For convention or membership information, call or write Kevin Walker, Executive Secretary, Medical Society of the U.S. and Mexico, 810 W. Bethany Home Rd., Phoenix, AZ 85013. (602) 246-8901.

14–17 **Rhinoplasty—A State of the Art Symposium**—Waldorf Astoria, New York City. Fee: $600, includes tuition, coffee breaks and luncheons. Credit: 21 hours Category 1. Contact: Francine Leinhardt, Plastic Surgery Clinic, Manhattan Eye, Ear & Throat Hospital, 210 E. 64th St., New York, NY 10021. (212) 838-9200, ext. 2776.

15–17 **Tumors of the Hand and Forearm**—Barbizon Plaza Hotel, New York City. Credit: 18.5 hours Cat. 1 of the Physician's Recognition Award of the AMA. Contact: American Society for Surgery of the Hand, 3025 S. Parker Rd., Suite 65, Aurora, CO 80014. (303) 755-4588.

16 **Paul R. Hackett Memorial Pediatric Anesthesia & Merry Simmons Critical Care Symposium**—Northglenn, Colorado. Designated for primary care physicians and specialists. Subjects: anesthesiology, critical care medicine, pediatrics. Hours of instruction: 6.5. Sponsored by The Children's Hospital, 1056 E. 19th Ave., Denver, CO 80218. Contact: Pamela C. Madden, Conference Planner, (303) 861-6949.

16–18 **Pulmonary Medicine & Office Spirometry for the Primary Care Physician**—Vacation Village Resort, San Diego, California. Fee: $295 physicians, $195 residents, allied health. Credit: 19 credit hours, AMA/CMA Cat. 1, California Board of Registered Nursing, American Academy of Family Physicians, American Osteopathic Association. Contact: Office of Continuing Medical Education, Univ. of Calif. School of Medicine, M-017, La Jolla, CA 92093. (619) 452-3940.

25–28 **14th Annual American Association for Hand Surgery**—Acapulco Princess Hotel, Acapulco, Mexico. Contact: American Association for Hand Surgery, 2564 Branch St., Suite B, Middleton, Wisconsin 53562. (608) 836-7880.

29–30 **A Special Workshop on the Use of the CO_2 Laser in ENT Surgery**—Kansas City, Kansas. Credit: 16 hrs. AMA Cat. 1, 15 hrs. AAFP. Fee: $600. Maximum attendance: 9. Contact: Jan Johnston, Office of Continuing Education, University of Kansas Medical Center, 39th & Rainbow Blvd., Kansas City, KS 66103. (913) 588-4480.

December 1984

2–6 **Hospital Medical Staff Conference & Hospital Trustee Forum**—Boca Raton, Florida, Boca Raton Hotel & Club. Contact: Estes Park Institute, PO Box 400, Englewood, CO 80151. (303) 761-7709.

6 **Neuropsychiatric Grand Rounds**—Pueblo, Colorado. 1-3 p.m. APA-approved course for Cat. 1 credit to examine the relationship of neurological and psychiatric disorders. Contact: Colorado State Hospital, James Scully, MD, 1600 W. 24th St., Pueblo, CO. (303) 543-1170.

6–8 **Hand Rehabilitation: An Audience Participation Seminar**—Houston, Texas. Tuition: therapists residents, fellows & allied health professionals $250; physicians $350. Credit: 17 hours Cat. 1. Contact: American Society for Surgery of the Hand, 3025 S. Parker Rd., Aurora, CO 80014. (303) 755-4588.

7–8 **Common Rheumatic Diseases for the Clinician**—Sacramento, California. Capitol Plaza Holiday Inn. Credit: 15 hours AMA/CMA Cat. 1. Tuition: $175 for physicians, $100 for all others. Contact: Office of Continuing Medical Education, School of Medicine, TB 150, University of California, Davis, CA 95616—Barbara Johnston, (303) 752-0328.

8–13 **Rhinoplasty—1984—American Academy of Facial Plastic Reconstructive Surgery**—Sonesta Beach Hotel & Tennis Club, Key Biscayne, Florida. Contact: Robert L. Simons, Md, 16800 NW 2nd Ave., Suite 405, North Miami Beach, FL 33169. (305) 652-4456.

13–14 **Advanced Trauma Life Support**—Kansas City, Kansas, Orr Major Hall, Univ. of Kansas Medical Center. Credit: 16 hours AMA Cat. 1, 15 hours AAFP, 15 hours AOA 2-D. Fee: $250. Maximum attendance: 16. Contact: Jody Scott, Department of Surgery, University of Kansas Medical Center, 39th & Rainbow, Kansas City, KS 66103. (913) 588-6124.

13–16 **Acetabular & Lower Extremity Fracture Management Symposium**—Stateline, Nevada, Caesars Tahoe, South Lake Tahoe. Credit: 21 hours AMA/CMA Cat. 1. Tuition: $475 for physicians and $250 for all others. Contact: Office of Continuing Medical Education, School of Medicine, TB 150, University of California, Davis, CA 95616. Barbara Johnston, (916) 752-0328.

Drug Therapy Q & A

Occupational Exposure to Methoxyflurane

Request:

A young woman who works in a veterinary clinic has developed symptoms of extreme lethargy, confusion and slurred speech. This lady is regularly exposed to methoxyflurane in her workplace, since this anesthetic is routinely used for various surgical procedures in animals treated at the clinic. No scavenging or air filtration device is used in the operating room. Could this patient's symptoms be related to her occupational exposure to methoxyflurane?

Response:

Methoxyflurane is a volatile, halogenated hydrocarbon with a characteristic odor. It is used by inhalation for general anesthesia and occasionally for patient-controlled postoperative analgesia.

Reported effects from atmospheric exposure

Based on large scale surveys, operating room personnel are considered at risk for certain potentially serious medical problems due to occupational exposure to waste anesthetic gases. Renal and hepatic disorders, congenital anomalies and possibly cancer have been found with significantly greater prevalence in this population than in individuals not exposed to atmospheric anesthetics[1].

Methoxyflurance has been incriminated in producing many of these effects. Increased urinary excretion of fluoride[2] and kidney and liver dysfunction manifested as significant elevations in blood urea nitrogen, serum uric acid and serum alanine aminotransferase (SGPT) and serum aminotransferase (SGOT) have been reported in obstetrical delivery ward personnel following exposure to methoxyflurane[3]. These effects are similar to effects reported in patients anesthetized with methoxyflurane.

Central nervous systems' effects of occupational exposure have been infrequent. Subjects exposed for four hours to atmospheric concentrations of volatile anesthetics similar to those found in operating rooms scored significantly less on a battery of psychological tests of perceptual, cognitive and motor skills than did a similar group of control subjects[4,5]. However, similar trials in both volunteers[6,7] and operating room personnel[8] have failed to replicate these results. While most authorities agree that exposure to trace anesthetic gases is of concern, perceptible effects on psychomotor performance has not clearly been proven[9,10]. In concentrations below those which cause unconsciousness in humans, methoxyflurance generally leaves specific somatic-evoked responses fully intact; nonspecific somatic potentials are depressed by these concentrations[11]. The possibility of direct anesthetic-induced subcellular damage to cortical neurons and glial cells has been raised in some studies of animals chronically exposed to low concentrations of halogenated hydrocarbons, although the scientific validity of these findings has been questioned[12].

Headache or migraine-like symptoms are frequent complaints among both anesthetists and surgeons when methoxyflurance is used in areas without exhaust systems for anesthetic gases[13]. These effects may, however, be common among these individuals, since one survey of some 36 anesthesiologists reported a high incidence of unusual headaches (72 percent of respondents) as well as irritabilty (69 percent) and insomnia (55 percent). Such problems are probably due to the exceptional stresses of working in this critical area[14].

One case of fatigue, weakness and lethargy in a nurse anesthetist was reported in 1971 by Elder et al[15]. In this patient, a 33-year-old woman who was otherwise in excellent health, fatigue and general weakness with marked ptosis of the eyelids occurred each time she administered methoxyflurane for prolonged surgical procedures. Symptoms usually persisted for two to three hours after anesthesia administration had been discontinued. Such symptoms occurred only with methoxyflurane and not upon administra-

This bimonthly column is designed to provide Colorado physicians with specific answers to commonly-asked questions about drug therapy. The column is prepared by the staff of the Rocky Mountain Drug Consultation Center in Denver. All questions appearing in the column are generated by calls received by the center from physicians and other health professionals.

Physicians are encouraged to call the center at 893-DRUG in the Denver metro area or 1-800-332-6475 in other areas of Colorado for specific answers to any drug therapy questions, including adverse drug reactions, drug interactions, drug therapy of choice, investigational drugs, drug use in pregnancy, drug dosing in renal and hepatic failure and drug identification. The center is available from 8 a.m. to 5 p.m. Monday through Friday, with 24-hour on-call service.

The director of the Rocky Mountain Drug Consultation Center is Dennis R. Sawyer, Pharm.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center and the Medical Director is Earl Sutherland, MD, Ph.D., Assistant Professor of Medicine, University of Colorado Health Sciences Center.

The author of this month's articles is Larry K. Golightly, Pharm.D., Associate Director of the Rocky Mountain Drug Consultation Center.

tion of halothane, cyclopropane or nitrous oxide. Upon consent of the nurse anesthetist, controlled exposure to methoxyflurane vapor via face mask produced characteristic symptoms of weakness and ptosis. Administration of an anticholinesterase agent (edrophonium) and atropine intravenously led to subjectively complete resolution of symptoms within 10 minutes. The authors concluded that the patient experienced exacerbation of subclinical myasthenia gravis by occupational exposure to methoxyflurane. Symptoms did not recur when excess anesthetic gases were vented from the operating room.

Biopharmaceutics of methoxyflurane: Methoxyflurane exhibits unusual characteristics of distribution, metabolism and elimination in human and other mammalian systems. These properties may render it particularly liable to cause potential problems in occupationally-exposed individuals.

Methoxyflurane is the most lipid soluble of all clinically-used general anesthetics. It has unusually high solubility coefficients in blood and in nerve, liver, kidney, heart, skeletal muscle and fat tissues[16]. Because of this, methoxyflurane penetrates tissues readily and is widely distributed in the body. Sophisticated recovery studies[17] in patients undergoing anesthesia have demonstrated that even after 10 consecutive days of monitoring, approximately one-third of the dose of methoxyflurane administered via closed rebreathing circuit remained unaccounted for. This loss of drug probably was due, at least in part, to covalent bonding of the anesthetic to tissues, resulting in a time course for elimination which greatly exceeded the 10-day study duration[17,18]. Similar studies have demonstrated that methoxyflurane and its metabolites enter tissue storage depots and elimination continues for at least nine to 12 days following surgery[19].

Thus, methoxyflurane undergoes a very prolonged elimination process. This characteristic could conceivably lead to accumulation of the drug in chronically-exposed individuals. Corbett and Ball[20] found that end-expired air of anesthesiologists contained detectable concentrations of methoxyflurane for as long as 30 hours after exposure to vapors in the operating room during a single surgical procedure.

Not only does methoxyflurane undergo a seemingly slow removal from tissues, it enters a very complex elimination pattern. Metabolic products of human biotransformation of methoxyflurane include the following[21,22]: methoxydifluoracetic acid; dichloracetic acid; oxalic acid; formaldehyde; chloride ion; fluoride ion; organic fluorine.

The major metabolic pathways of methoxyflurane are elimination of unchanged drug in exhaled air (20 to 30 percent of an absorbed dose); inorganic fluoride ion excretion in urine or deposition in bone (15 percent of a dose); organic fluorine excretion in urine (approximately 30 percent of a dose); and production of smaller amounts of oxalic and other organic acids which are primarily eliminated through renal mechanisms. Methoxyflurane has not been demonstrated to be cytotoxic to liver or kidney cells in vitro[22], although one or more of its metabolites may be directly responsible for the major toxicities of the drug as described below.

Major systemic toxicities

Biochemical perturbations in renal function have been described in individuals occupationally exposed to methoxyflurane[23]. Acute polyuric renal failure associated with methoxyflurane, including several fatal cases[24,26], has been reported in a substantial number of patients undergoing anesthesia[27,34] and this disturbing problem has been widely editorialized[35,37]. Renal toxicity has been proven to be dose-related[38,40] and probably due to either direct nephrotoxic effects of fluoride, renal tubular deposition of oxalate crystals, or both. Serious kidney damage is uncommon after low doses[41,44], although transient decreses in renal function occur commonly with even relatively brief, low-concentration anesthesia[45,46]. Whether chronic exposure to low concentrations of methoxyflurane may lead to renal toxicity is unknown, although at least one case of renal disease, hypertension, and skeletal fluorosis has been reported in association with chronic illicit use of the drug by inhalation[47].

Hepatitis[48,50], hepatic coma[51] and fatal hepatic necrosis[52,53], have occurred following anesthesia. Elevations in liver enzymes have been reported in operating room personnel administering methoxyflurane 3 and fulminant hepatitis has occurred in an individual chronically sniffing the drug as an euphoriant[54]. Both renal and hepatic failure may occur concurrently in methoxyflurane toxicity[55]. Other prominent features of methoxyflurane associated liver include previous exposure to halogenated anesthetics in 50 percent of cases, a histologic appearance indistinguishable from viral hepatitis, a non-dose-related occurrence and a 58 percent mortality rate[56]. Again, as with renal disorders, whether operating room exposure to methoxyflurane presents a significant risk for liver toxicity is unknown.

Summary and conclusion

Chronic exposure to anesthetic gases may present health risks to operating room staffs and venting systems are generally recommended to reduce possible adverse effects[1]. Repeated exposures to low concentrations of methoxyflurane have been associated with biochemical evidence of kidney and liver injury. Adverse CNS effects have been infrequent, although headaches may occur commonly upon inhalation of vapors in the surgical suite. Decreases in performance of psychomotor skills have been suggested but not proven in association with operating room exposure. One case of extreme weakness, fatigue and ptosis has been described in a nurse anesthetist with subclinical myasthenia gravis following methoxyflurane administration. Thus, no clear association with the symptoms on the present patient and methoxyflurane can be made based on published data, although such a relationship would seem a possibility.

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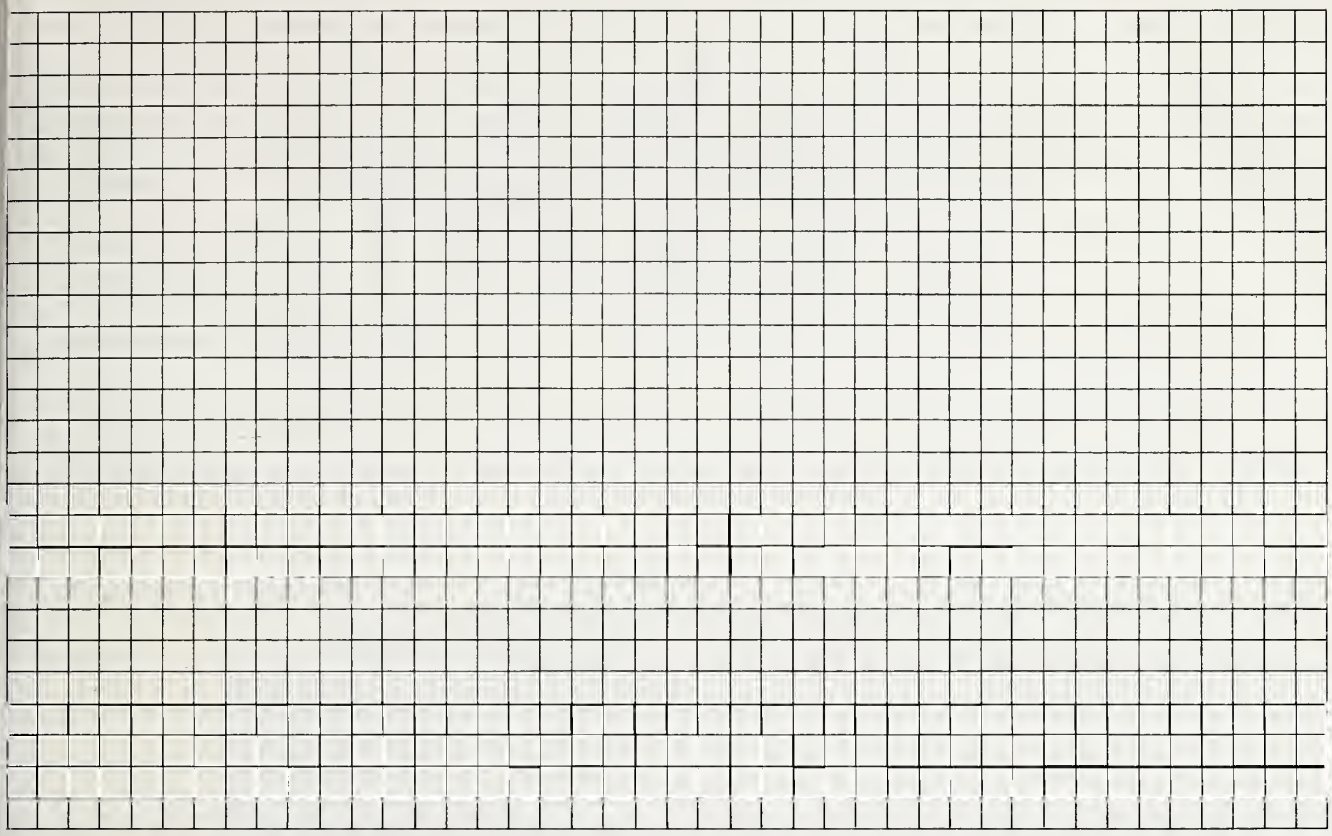
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Family Practice in Rural Colorado

In recent years, Colorado has attracted a flood of newcomers of every description and profession. Physicians, like so many others, find Colorado's attractions very appealing. But of the many physicians who have come to Colorado in the last few years, how many have gone to the rural areas which lack sufficient medical care?

One recent study indicates that many rural Colorado areas still lack enough physicians. A report on this problem begins on p. 319.

What can be done about the rural physician shortage? A two-tiered program at the University of Colorado has targeted both the lack of physicians in rural and the problem of rural health education. See p. 313.

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president's letter



W. Gerald Rainer, MD
President, Colorado Medical Society

Responses from Members

—Uneasy lies the head that wears the crown
Shakespeare, King Henry IV

Schedules are sometimes not synchronized for effect. For that reason, it seems odd to write to the membership in mid-November in the midst of pressing issues knowing that when this message reaches the readers, it will be early December. Most likely, by that time we will have succeeded in our efforts to "Save the Society" or we will no longer exist.

At this point in time, I remain optimistic. And I hope by the time this message is published, we will have started the long, slow road to recovery.

When the letter went out from CMS headquarters with the urgent plea for help and the answers to frequently-asked questions, the response was enormous—most of it supportive and heart-warming. There were many responses that reflected indignation, anger, infuriation—not surprising or totally unexpected. However, the important issue is that *there was response*. For once, it seemed that the CMS leadership was communicating with the members—and even angry responses indicate concern.

We had many recommendations and suggestions (some unprintable) of how to extricate the Colorado Medical Society from its present situation. Many of these suggestions were sincere and thoughtful, but time constraints did not permit implementation of alternate plans.

In among the responses I sensed several sentiments:

CMS belongs to the members.

1. Insure new leadership—this has already been accomplished.

2. Avoid getting into similar situations in the future. A recommendation has already gone from the Board of Directors to the Organizational Study Committee to devise a mechanism whereby future projects of certain magnitude will require referendum approval by the membership.

3. Genuine support for the survival of CMS. It is encouraging to know that most members are dedicated to continuation of our involvement in organized medicine and declaration of bankruptcy is totally unthinkable.

4. Need for continued communication to the membership—this current leadership has dedicated itself to *continued* communication with component societies and the membership. The doors of the Colorado Medical Society and the telephone lines are available to all members at all times. *The Colorado Medical Society belongs to the members!*

To those who have voiced support for CMS—thank you. some of the letters and thoughts were masterpieces. To those members who have raised objections, thank you for taking time to voice your concerns. To those *very few* who have left CMS, I consider it a challenge to help improve things enough to make you want to return.

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auxiliary report

The Auxiliary's Legislative Effort



Mary Hanson, President
Colorado Medical Society Auxiliary

The election of 1984 is history. The medical community of Colorado responded to the Medvote '84 campaign with flying colors. More physicians and their families were registered to vote than ever before and, we hope, exercised that privilege. Congratulations to all who worked so diligently on that project.

The state and the nation will be facing more and tougher medical legislation than at any time in the recent past. Among the bills to be considered will be legislation by other health care providers, including bills involving privileges of podiatrists, chiropractors and psychologists. Other areas of interest to the medical community are health care funding for the medically indigent, hospital-physician relationships and the formation of a health care data commission. "Living wills," mandatory seat belt and motorcycle helmet laws are but a few more issues being considered for the 1985 agenda.

The CMS Auxiliary continues to work in the legislative arena by conducting programs around the state to the county auxiliaries. To be better informed regarding current legislative issues and to better understand the process under which our laws are constructed will help us to be more effective lobbyists for our views. Our efforts in the legislative arena cannot stop with the election. The ongoing task of working with the legislators we have elected is of paramount importance. They expect and deserve our attention throughout the legislative session coming up in January. When medical issues are addressed, they welcome the expert and informed opinions of the medical community.

It is also a responsibility to respond and to continue our interest in all legislative matters that affect the quality of life in Colorado. Our credibility is greatly enhanced when we contact a legislator in an area other than the health care field. We all have interests other than those affecting the practice of medicine and these are interesting and valuable to the legislators as well. Only with a sustained and genuine effort of interest can we expect to be heard.

Happy holidays to you all!

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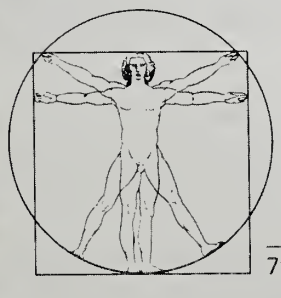
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The New "Veto-Proof" Colorado Legislature

The big election is now a month old, and new senators and representatives are becoming used to being addressed with "The Honorable" as a prefix. One new congressman will represent us in Washington, Mike Strang from Carbondale. Individual physicians and CMS were active in his campaign, and we look forward to a good relationship with his office.

The Colorado legislature is now veto-proof, meaning that there are enough Republican votes in both houses to override Governor Lamm's veto. This may mean that some measures not passed in recent years because of his threatened veto will now be attempted. There are seven new faces in the Senate; but four of those currently serve in the House of Representatives, two are former senators, and the seventh has been serving as secretary to the minority leader. There are 18 new members of the House for about a 28 percent turnover. All of the new people will be trained the first week in December and begin making requests for committee assignments.

And then comes swearing in on January 2nd and we will be off and running.

U. S. Senate: Bill Armstrong (R)* and Gary Hart (D)*

U. S. House of Representatives: District 1—Patricia Schroeder (D)*; District 2—Timothy Wirth (D)*; District 3—Mike Strang (R); District 4—Hank Brown (R)*; District 5—Ken Kramer (R)*; District 6—Dan Schaefer (R)*.

Colorado Senate

District 1—Jim Brandon (R)* Counties of Kit Carson, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma.
District 2—James Rizzuto (D)* Counties of Baca, Bent, Cheyenne, Crowley, Huerfano, Kiowa, Las Animas, Otero, Pueblo, Prowers
District 3—John Beno (D)* County of Pueblo
District 4—Harold McCormick (R)*† Counties of Custer, Fremont, Lake, Park and Pueblo

There are enough Republican legislators to override the Governor's veto.

District 5—Michael Callihan (D)* Counties of Alamosa, Chaffee, Conejos, Costilla, Delta, Gunnison, Hinsdale, Mineral, Rio Grande, Saguache
District 6—Dan Noble (R)* Counties of Archuleta, Delta, Dolores, La Plata, Montezuma, Montrose, Ouray, San Juan, San Miguel
District 7—Tilman "Tillie" Bishop (R)*—County of Mesa
District 8—David Wattenberg (R) Counties of Garfield, Grand, Jackson, Larimer, Moffat, Rio Blanco, and Routt
District 9—Joel Hefley (R)* Counties of Elbert, El Paso
District 10—Ray Powers (R)* Counties of El Paso and Lincoln
District 11—Jeff Wells (R)* County of El Paso
District 12—Steven Durham (R) Counties of El Paso and Teller
District 13—Tom Glass (D)* Counties of Boulder, Clear Creek, Eagle, Gilpin, Jefferson, Pitkin, and Summit
District 14—James Beatty (R)* County of Larimer
District 15—Wayne Allard (R)* Counties of Larimer and Weld
District 16—John Donley (R)* County of Weld
District 17—Les Fowler (R)* County of Boulder
District 18—Jana Mendez (D) County of Boulder
District 19—Al Meiklejohn (R)* County of Jefferson
District 20—Claire Traylor (R)* County of Jefferson
District 21—Jim Lee (R) County of Jefferson
District 22—Kathy Arnold (R)* County of Jefferson
District 23—Ted Strickland (R)* County of Adams
District 24—Polly Baca (D)* County of Adams
District 25—Bob Martinez (D) County of Adams
District 26—Martha Ezzard (R)* County of Arapahoe
District 27—Ralph Cole (R)* County of Arapahoe
District 28—Jack Fenlon (R) County of Arapahoe
District 29—Joe Winkler (R)* Counties of Arapahoe, Douglas and Jefferson
District 30—Dennis Gallagher (D)* County of Denver
District 31—Don Sandoval (D)* County of Denver

*Denotes incumbent
†New district as per reapportionment



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District 33—Regis F. Groff (D)* Counties of Adams and Denver
District 34—Paul Powers (R) Counties of Arapahoe and Denver
District 35—Cliff Dodge (R)* Counties of Arapahoe and Denver

Colorado House of Representatives

District 1—Jeanne Faatz (R)* Counties of Denver and Jefferson
District 2—Tony Hernandez (D) County of Denver
District 3—Wayne Knox (D)* County of Denver
District 4—Robert Bowen (D)* County of Denver
District 5—Philip Hernandez (D)* County of Denver
District 6—Jerry Kopel (D)* County of Denver
District 7—Gloria Tanner (D) Counties of Denver and Adams
District 8—Wilma Webb (D)* County of Denver
District 9—Pat Grant (R) Counties of Arapahoe and Denver
District 10—Betty Neale (R)* Counties of Arapahoe and Denver



Rehabilitation Groups of the American Cancer Society

Reach to Recovery

Reach to Recovery is a rehabilitation group for women who have had breast surgery. It is designed to help them meet their physical, psychological, and cosmetic needs. Volunteers, who have been selected by their doctors and have completed training, visit the patients in the hospital with the physician's approval. No medical advice is given but compassion and emotional support are available.

For more information,

American Cancer Society
Colorado Division, Inc.
321-2464

District 11—Dottie Wham (R) Counties of Arapahoe and Denver
District 12—Betty Swenson (R) County of Boulder
District 13—Sandy Hume (R)* County of Boulder
District 14—David Skaggs (D)* County of Boulder
District 15—Ruth Wright (D)* County of Boulder
District 16—Mary Anne Tebedo (R)* County of El Paso
District 17—Barbara Philips (R) County of El Paso
District 18—Michael "Mike" Bird (R)* County of El Paso
District 19—Peter Minahan (R)* County of El Paso
District 20—Mary Dambman (R)* County of El Paso
District 21—Charles "Chuck" Berry (R) County of El Paso
District 22—John Herzog (R)* County of El Paso
District 23—Marleen Fish (R) County of Jefferson
District 24—Bonnie Allison (R)* County of Jefferson
District 25—Tony Grampsas (R) County of Jefferson
District 26—Don Mielke (R)* County of Jefferson
District 27—David Bath (R)* County of Jefferson
District 28—Richard Mutzebaugh (R)* County of Jefferson
District 29—Carol Taylor-Little (R)* County of Jefferson
District 30—Margaret "Molly" Markert (D)* County of Adams
District 31—Dale Erickson (R) Counties of Adams, Boulder and Weld (probable recount)
District 32—Jeannie Reeser (D) County of Adams
District 33—Kathi Williams (R) County of Adams
District 34—Mike Bird (R) County of Adams
District 35—JoAnn Groff (D) County of Adams
District 36—John Singer (R) County of Arapahoe (probable recount)
District 37—Chris Paulson (R)* County of Arapahoe
District 38—Phillip Pankey (R)* County of Arapahoe
District 39—Paul Schauer (R)* County of Arapahoe
District 40—Charles "Bud" Hover (R)* Counties of Arapahoe, Douglas and Elbert
District 41—Stanley Johnson (D)* County of Pueblo
District 42—Gilbert Romero (D) County of Pueblo
District 43—Larry Trujillo (D)* Counties of Huerfano, Las Animas, Otero and Pueblo
District 44—Bob Leon Kirscht (R)* Counties of Fremont and Pueblo
District 45—Cliff Bryan (R)* County of Larimer
District 46—Ronald Strahle (R)* County of Larimer
District 47—James "Jim" Brown (R) County of Larimer—(probable recount)
District 48—Bill Artist (R)* Counties of Larimer and Weld
District 49—Bill Owens (R)* County of Arapahoe
District 50—Richard "Dick" Bond (D) County of Weld
District 51—Walter Younglund (R)* County of Weld
District 52—James Moore (R)* County of Jefferson
District 53—Jim Scherer (R)* Counties of Clear Creek, Gilpin, Jefferson and Summit
District 54—Ed Carpenter (R) Counties of Delta and Mesa
District 55—Vickie Armstrong (R)* County of Mesa
District 56—Dan Williams (R) Counties of Eagle, Grand, Jackson, Moffat, and Routt
District 57—Scott McGinnis (R)* Counties of Eagle, Garfield, Pitkin, and Rio Blanco
District 58—Glenn Underwood (R)* Counties of Delta, Dolores, Montezuma, Montrose, Ouray, and San Miguel
District 59—Ben Nighthorse Campbell (D)* Counties of Archuleta, La Plata, Montezuma and San Juan
District 60—Lewis Entz (R)* Counties of Alamosa, Conejos, Costilla, Gunnison, Hinsdale, Mineral, Rio Grande, and Saguache
District 61—Robert Shoemaker (D)* Counties of Chaffee, Custer, Fremont, Lake, Gunnison, Park, and Teller
District 63—Elwood Gillis (R)* Counties of Baca, Bent, Crowley, Kiowa, Otero and Prowers
District 64—Carl "Bev" Bledsoe (R)* Counties of Adams, Arapahoe, Cheyenne, Elbert, Kit Carson, Lincoln, Phillips, Washington and Yuma
District 65—John Hamlin (R)* Counties of Logan, Morgan and Sedgwick

copic report

New Insurance Products Available Through CMS and COPIC



K. Mason Howard, MD, Chairman
Harry E. Grant, Manager, COPIC Insurance Agency

One of the continuing objectives of the Board of Directors of the Colorado Medical Society is to provide many avenues by which members can obtain help with various problems as they practice medicine day to day. As insurance coverages become more complicated there must be a commitment to advocacy for physicians as well as improved methods to pass along new insurance data and programs.

When the Board of Directors established the Professional Liability Trust in June 1981, it was their intention to provide quality professional liability coverage with long-term stability. In 1984, COPIC Insurance Company was licensed by the state to continue this commitment. In addition, however, there are other lines of insurance which physicians require which are not available through COPIC Insurance Company. In order to provide expanded service in areas other than professional liability, the COPIC Insurance Agency was licensed in 1984 to act as an advocate for Colorado physicians. The agency is the vehicle which will deliver the policy coverage and offer a full range of service in other property and casualty areas. Agency representatives are available to assist physicians when they have questions concerning property and casualty coverages. To be fully protected, a physician must carry coverages such as office packages, miscellaneous medical, as well as personal coverages such as homeowners and auto insurance.

The Colorado Medical Society has appointed Smith & Prostrollo as special agents to provide life, disability and health benefit coverages to CMS members. Messrs. Smith and Prostrollo are qualified insurance counselors, ready to answer your questions regarding these coverages.

Due to the complexity of insurance it is a real benefit to CMS members to have insurance experts in property, casualty, life, disability and health lines to assist them in making sound insurance judgments. The objective of these entities is to provide expertise relative to physician insurance programs. The difference between CMS insurance professionals and outside sources is that we act as your insurance advocate, without obligation to buy our product. Naturally, if we perform well we would appreciate the opportunity to serve you.

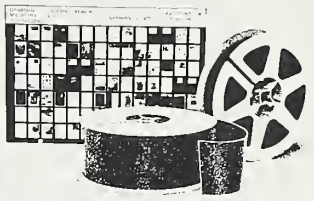
COPIC Insurance Agency will offer a full range of services.

The COPIC Insurance Agency has direct access to special insurance plans available through major commercial insurers such as St. Paul and the Unigard groups. These companies will be able to handle most of your coverage needs. However, if we do not have the best market available, we can put you in touch with agents in your area who represent specialized markets. Our insurance professionals will objectively evaluate your present coverages, make recommendations if necessary, or even advise you to continue with your present insurance program, if appropriate. An important factor when utilizing CMS insurance professionals is your assurance that when you buy insurance through these advisors, it will do the job that was outlined in the proposal.

There are many changes taking place in the insurance industry today. It's incumbent upon knowledgeable insurance professionals to be sure the buyer fully understands what protection is required and how to maintain proper coverage. Just as you, the physician, offer informed consent regarding medical procedures, we as insurance professionals must properly inform you about the insurance product you purchase. If, upon our review you are satisfied with your present product, we have performed the desired service. If we can recommend improved coverages, we trust we have earned the right to secure this protection for you.

Please feel free to call us any time we can be of assistance !

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letters to the editor

Thanks CMS

To the editor:

I am writing this letter to show my deepest appreciation to the Colorado Medical Society and its staff. I am head of the Colorado Seat Belt Coalition which was formed about six months ago. Without the help of the Colorado Medical Society staff, this organization would have had a hard time functioning. The seat belt issue is just one of many issues that are important to organized medicine at this time. We as physicians need the expert help that the Colorado Medical Society can provide us in these tough times for medicine.

Please support the Colorado Medical Society for without it we as individual physicians will not be able to combat the difficult times that are ahead for us.

Once again, thank you, Colorado Medical Society, for a great job!

Sincerely,

Denis R. Elo, MD, FACS

Editor's Note: Dr. Elo will be a guest on the television program "Dimension 4" during the weekend of December 29. He will discuss seat belts and related issues. Other recent guests on the CMS segment of the program have included Dr. Stephen B. Cantrill of Denver, who discussed the proposed motorcyle helmet law, and Dr. David Simmons of Greeley, who spoke about the recent CMS resolution regarding the health and sanitary conditions of Colorado migrant farm workers.

To the editor:

Thank you for your call in regard to reprinting our article on a positive health strategy for the physician's office.

Colorado Medicine is a very well-designed publication that actively involves the reader. I would be interested to learn some of the suggestions you might have concerning the coverage of socioeconomic issues. As you know, the *New York State Journal of Medicine* is akin to *The Western Journal of Medicine* in being primarily a scientific publication. However, we are trying to include more material on socioeconomic and legislative issues.

Again, it was good to speak with you and I look forward to continuing our dialogue.

Sincerely,

Alan Blum, MD
Editor
New York Journal of Medicine

obituaries

Ward C. Fenton, MD, of the Otero County Medical Society died June 19, 1984 in Kalispell, Montana.

Dr. Fenton was born August 6, 1898 in Rocky Ford, Colorado. He attended the University of Colorado and received his medical degree from Washington University in St. Louis, Missouri in 1922.

From 1922 to 1923 he interned at the Methodist Hospital in Omaha. He did a residency at Santo Tomas Hospital, Canal Zone, Republic of Panama.

Dr. Fenton married Charlotte Burgess on December 29, 1923 in Waterloo, Nebraska.

He opened his medical practice in Rocky Ford in 1925. With the exception of military service in the U.S. Medical Corps from 1942 to 1946, Dr. Fenton practiced in Rocky Ford until his retirement in 1973.

Memberships included the American Medical Association, the American Legion, the Lions, Elks and the Masonic Lodge.

Dr. Fenton is survived by his wife; a son and daughter; four grandchildren and two great-grandchildren.

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AMA To Develop New Physician Relative Value Scale

The development of a national physician relative value scale (RVS) may counter a potential legislative thrust toward physician diagnostic related groups (MDDRGs).

On October 15, 1984, at the invitation of the American Medical Association, representatives from national specialty medical societies met in Chicago to discuss the development of a new physician RVS. W. Gerald Rainer, MD, representing the American Society of Thoracic Surgeons, and Joe F. Turnbow, MD, representing the American College of Emergency Physicians, attended from Denver.

Jerald Schenken, MD, chairman of the AMA Council on Legislation reviewed the problems that the United States Congress and federal administration have with the current physician reimbursement system. He stated that the current fee freeze mandated by Congress is only a stop-gap measure and noted that Congress is moving in the direction of physician DRGs.

Lonnie Bristow, MD, chairman of the AMA Council on Medical Services, stated that the AMA supports the development of a relative value system based on resource costs which consider the cost of production time, complexity, required skills, overhead, liability and training.

AMA Executive Vice President James Sammons, MD, said that the AMA will seek a contract with HCFA to develop a physician RVS. The AMA hopes that such a scale may be accepted by the federal government in place of physician DRGs.

Dr. Rainer told the group that he was concerned that physicians could not develop the RVS before having MDDRGs forced on them. Dr. Bristow responded by reviewing several of the problems associated with MDDRGs. He further noted that only 13 percent of physicians in the nation currently are participating physicians in Medicare. He said he felt that this situation will make Congress more sensitive to the acceptance by physicians of federal programs. He added, "It may show that doctors cannot be so easily jerked around by the dollar bill."

Dr. Turnbow stated, "The Council on Legislation, the Council on Medical Services and the AMA House of Delegates feel that Congress is on a steamroller towards MDDRGs. They feel that this would destroy or severely disrupt the system of medicine as we know it. Development of a relative value scale based on resource costs for all physicians' services would be an attempt by medicine to provide an alternative to the administration and to Congress in their attempts to revise physician reimbursement. It is felt that this plan has some chance of success. Certainly, any such system must be developed carefully with input from all provider interests, and it must be fair to provide credibility. Each medical specialty society will be asked to participate in the planned development of the RVS."

Dr. Turnbow went on to warn that "the most likely scenario is one in which each specialty society demands a bigger piece of the pie for itself. The American College of Emergency Physicians believes that the most serious threat to us all lies outside of the house of medicine and questions if each specialty will be able to lay aside its own interests in order to have a chance at salvaging some resemblance of the fee-for-service system. It is imperative that we do so."

Dr. Stein Elected Vice Speaker of ASA

Donald W. Stein, MD, was elected vice speaker of the American Society of Anesthesiologists (ASA) at the society's recent annual meeting. The ASA is the nation's sixth largest medical specialty group with 20,000 members.

Dr. Stein is affiliated with the United Medical Staff of Boulder, Colorado, which serves Boulder Community and Boulder Memorial Hospitals. He is also on staff at four Denver hospitals.

A former director of the ASA, Dr. Stein is a past president of the Colorado Society of Anesthesiologists and the Boulder County Medical Society. He has served as chairman of anesthesia service at Rose Medical Center in Denver and as the first chairman of the Department of Anesthesia of the United Medical Staff of Boulder.

Dr. Stein is an associate clinical professor of anesthesia at the University of Colorado Medical School. Other memberships and activities include the American Medical Association, the Colorado Foundation for Medical Care, the American Society of Regional Anesthesia, the Society of Obstetrical Anesthesia and Perinatology and the Academy of Anesthesiologists.

Oregon Participation in Medicare

"Participation" in the Medicare program by Oregon physicians is approximately 10 percent, according to information obtained by Oregon Medical Association President Thomas R. Reardon, MD. Dr. Reardon said he was not surprised by the large number of doctors who did not sign the new participating agreement and urged those doctors to explain to their patients that "non-participating" physicians may still accept Medicare assignment and will continue to care for their patients just as they always have.

"We must make it very clear that our patients' well-being will always be our main concern and we must be ready to answer their questions about the new Medicare program," he said.

AMA President Joseph F. Boyle, MD, had a similar message for a group of more than 200 OMA members who gathered to hear him speak in Portland recently.

"The health and welfare of our patients shall be our first consideration, not allowing economics, politics, race, religion or any other circumstance to take precedence," he said.

RTD Supports Ban on Tobacco and Alcohol Advertising

Editorial Note: The following letter was sent to CMS President W. Gerald Rainer, MD and Past President John A. Whitesel, MD. CMS, through the Council on Public Health and the Interagency Coalition on Smoking and Health, has become active in promoting nonsmoking. The November issue of Colorado Medicine *included an article advocating a ban on cigarette advertising.*

Dear Dr. Rainer:

You will be pleased to know that at the October 30, 1984 meeting of the RTD Board of Directors, action was taken to uphold the ban on tobacco and alcohol advertising.

We are particularly pleased to have had the opportunity to respond to community concern, and we thank you for bringing this issue to our attention. Community input is essential to our goal of making RTD the finest transit authority in the nation and we look forward to receiving your continued interest and support.

Sincerely,

Regional Transportation District
Byron L. Johnson
Chairman of the Board

SEARCH Program Targets Rural Physician Shortage

Editorial Note: The following article was written by Olivia de Castanos, an information specialist with the University of Colorado Health Sciences Center News Media Relations Office.

Whatever happened to the family doctor who toted his black bag to your house to check on a lingering case of the sniffles? Or the gentle-mannered physician who delivered your children?

He's in Wray, Granby, Montrose, Delta, Trinidad, Walsenburg—and the hundreds of little towns and communities in 26 Colorado counties that have been designated shortage areas for primary care medical manpower.

In towns like these, the local doctor is a familiar face; he may be just as familiar to the children in the schoolhouse as he is to the old lady down the street. He probably sits on the school board, too, and is active in a half-dozen local community organizations. In short, he's the integral and omnipresent figure once characterized so affectionately in family television programs.

But as that kind of TV program seems to be dying out, so too does the small-town Colorado doctor.

When "Doc" passes on, many rural communities will be left with no one to administer complete medical care. Other towns have never had their own physicians. Many communities are populated by people who assume that basic medical care means having to travel many miles.

The issue isn't so much the comfort of having an old friend just a few minutes away who knows how to treat a sprained ankle, or the convenience of taking your baby just a half-mile for his vaccinations. It's the need to be able to have a broken bone set without subjecting the patient to a rocky ride over miles of terrain. It's the urgency to diagnose an aneurism in a young athlete before it's too late, or to treat the elderly woman whose heart is about to fail.

The picture is bleakest in the 14 Colorado counties fully designated as primary care manpower shortage areas. None of these lies in a standardized metropolitan statistical area (SMSA) and none contains a town of as many as 10,000 people.

To put the figures on a more personal level, about one in every five Coloradans resides in a place with a population of less than 2500 (defined as a rural area by the United States census) and most live outside a town. These people often have no access to a physician; not only in the nearest community, but also in their entire civil census district. For all civil census districts with no town of as many as 2500 people, the population-to-physician ratio, in 1980 was 3489 to one.

Is the small-town doctor dying out?

For reference, of Colorado's total population of 3.1 million, 1.7 million are concentrated in the greater Denver area. Of the state's 63 counties, 10 are classified as urban, all of them having a population of more than 80,000. Of the 53 rural counties, each has fewer than 30,000 people, with no single community of more than 13,000.

The Colorado SEARCH/AHEC program was established in 1977 to address this maldistribution of health manpower resources in the state. And if the input and data currently available are any indicator, it has begun to make its impression on the physicians of tomorrow—and today.

The decentralization of health education

The original AHEC (Area Health Education Center) program was one of a number of federal and state programs initiated during the early 1970s to decentralize health education and deal with the maldistribution of health providers. It began in 1972 when, under authorization of the Health Manpower Act of 1971, the Department of Health, Education and Welfare awarded contracts to 11 schools of medicine to plan, develop and implement AHEC programs as first described by the Carnegie Commission on Higher Education.

The Health Professions Education Assistance Act of 1976 authorized funding of a second generation of AHEC programs, of which the Colorado program was one. Operated by the University of Colorado (CU), it was entitled SEARCH (Statewide Education Activities for Rural Colorado's Health). Four AHECs were incorporated to cover 53 countries and were in operation by the end of 1978. The AHECs are local, independent, non-profit organizations, consisting of a regional board of directors and staff that contract with SEARCH for services.

Centennial AHEC, Inc., is based in Greeley and serves the 10-county northeast quadrant of the state, with a population of 335,738. Southeastern AHEC, Inc., located in Pueblo, serves health providers for the 265,000 people in the 16-county southeastern quadrant. The San Luis Valley AHEC, based in Alamosa, serves the six-county San Luis Valley, with its population of 37,674; and the Western Valley AHEC, in Grand Junction, serves Western Slope health providers in a 21-county area of 288,895 people.

The SEARCH/AHEC program takes a multidisciplinary two-pronged approach to alleviating the

maldistribution of health manpower in rural areas. One, it helps attract new health care professionals (including nurses, dentists, nurse practitioners, physical therapists, pharmacists, technicians and all other allied health providers, as well as physicians) to underserved areas through student/resident rotations. Two, it helps retain the professionals already in the rural areas by providing accessible continuing education and student-teaching opportunities.

Each AHEC office cooperates with the faculty of the schools of the CU Health Sciences Center (HSC) in Denver, as well as the SEARCH office, in coordinating the placement of students and residents with preceptors, health care professionals in rural areas who have a clinical faculty appointment at the UCHSC. The AHECs help arrange housing and support services for the students to ease the transition from a familiar environment.

The rural rotations, generally referred to as preceptorships, are "a form of educational intervention. They show students what it's really like to practice medicine in rural areas. It breaks down their biases and misperceptions and points up opportunities," according to Karen Hansen, director of the SEARCH program at the health sciences center.

The medical student rotations consist of two-week periods of observations experience in the first and/or second year of school and four-to-six week periods of clinical experience in the third and/or fourth year. Third-year preceptorships are available in medicine, surgery, pediatrics, obstetrics-gynecology and psychiatry, and seniors may take primary care clerkships and subspecialty rotations in areas such as dermatology and neurology. The length and number of rotations yearly can be tailored to each student's situation, Ms. Hansen noted. And clinical experiences in a rural rotation are totally voluntary, she added.

How students benefit from rural rotations

Why would students volunteer to spend time away from home, friends, family and the sophisticated educational environment in which they receive most of their medical training?

"There's something qualitatively different about a community-based environment than a university-based one. It gives students a chance to practice preventive medicine, family medicine," according to Ellen Tabak, academic coordinator of the preceptorship program and a senior instructor with the CU School of Medicine.

"It's a hands-on, practical, true-to-life application of what is theory in the classroom," said Robert Guthmann, Jr., executive director of the Centennial AHEC in northeast Colorado. Terming the preceptorships "an exceptional learning experience," he noted that they give the students a chance to experience the "healing touch" of medicine, not possible through observation.

Indeed, many of the comments from students who have served a rural rotation reflect their appreciation of being allowed to relate to the students directly and personally.

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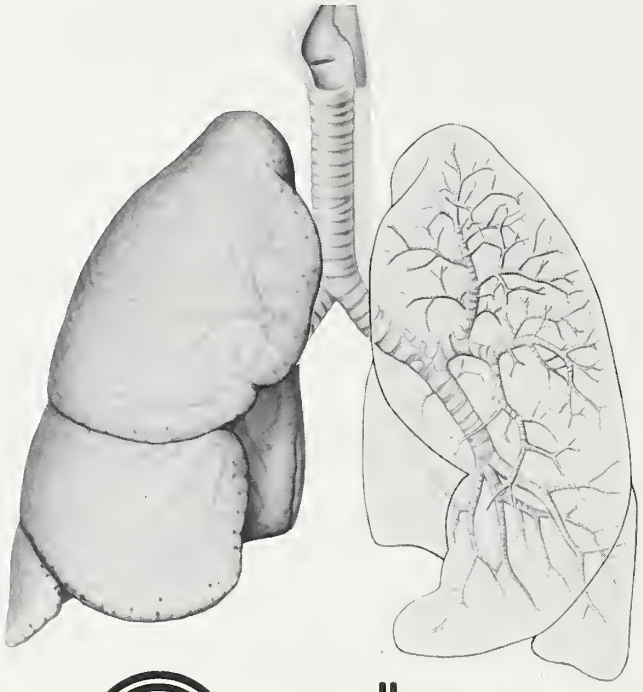


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Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions. *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor* (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.16, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note. Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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a junior-year rotation in Glenwood Springs commended her "very knowledgeable preceptor who allows the student to do as much as she is capable of with the permission of the patient." She said she was "really able to deal personally with patients and see how the private 'small-town doc' lives."

"I experienced excellent teaching in a non-threatening situation. There was a broad range of patients for me to be involved with," recollected a student specializing in pediatrics who spent her preceptorship in Grand Junction.

"Students say, 'At medical school, we deal with the esoteric'," commented Al Kelly, executive director of the San Luis Valley AHEC. "Here, they deal with the kind of real, everyday problems they'll be confronted with later."

The not-at-all contradictory qualities of freedom and attention also were cited as rewards of rural rotations by AHEC directors and students alike.

"Doctors (and, hence, students) get more attention in a smaller community," noted Ms. Tabak.

"The students indicate they are given more freedom and opportunity to go out and practice as a physician than they are in city hospitals," explained Mr. Guthmann. He attributed that phenomenon to the fact that the student probably is the only student in that community, not one of many.

"More responsibility created a more valuable experience. I was prompted to learn more since I was expected to know things," asserted a junior-year psychiatry major of her preceptorship in Pueblo. "Also, there was a greater amount of time spent with the preceptor here, which facilitated learning to a great extent." The student "functions as a physician in this setting."

The more comprehensive approach to medicine practiced by a rural physician also influences the students who spend time in a community environment.

"They see cases such as diabetes earlier, from the beginning, and follow the patients through," Ms. Tabak said. "They see the family in other settings and often get involved in the politics of the town."

"It was a good experience to be able to care for very ill, hospitalized patients, as well as patients who were followed for chronic diseases or non-severe acute illnesses in the clinic," said a junior-year student about her preceptorship in Greeley. "This experience gave me a better idea of what the practice of internal medicine is all about."

Perhaps the most important aspect of the rural preceptorship is the student's familiarization with the practice of medicine without advanced equipment or easily accessible tertiary care facilities.

"If a patient comes in from a car accident, the small-town doctor can't send him to the medical center hospital across town. He has to take care of (the problem) himself," Ms. Tabak explained. "He has to talk to the patients and use his senses, rather than relying on fancy equipment. He would use it if he had it, but he doesn't."

Do their SEARCH preceptorships change the opinion of medical students about practicing in rural environments?

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here, they think they're going to find a lot of dumbos," Mr. Kelly commented. "Instead, they find there are very competent physicians here, even though we don't have all the fancy equipment. They can't get enough of us."

Thomas Flower, DO, a family medicine physician who has been a preceptor since the program's inception, concurred that spending time in rural areas "allows the students to be less scared and to see that people can practice good medicine in a rural area."

Surveys have verified the impressions of students and preceptors involved in the student rotations. In addition, scientifically-designed scoring techniques have shown that the students, on the whole have been "receiving education on par with that provided at tertiary care centers," according to one report. The report also notes that "Students receive at least as good and in some ways better educational experience in decentralized sites where they are sensitized to health problems in rural areas, see 'real' medicine in action and are afforded the opportunity to learn about cross-cultural issues in medical care."

There's a spin-off benefit to the SEARCH program. "The CU School of Medicine wouldn't be able to carry out its primary care course without the SEARCH program," Ms. Tabak said. The course, a senior-year requirement for medical students, consists of clinical experience through a doctor's office or other health care facility. About half the students stay in Denver, while the other half take the course in rural areas, Ms. Tabak added. To point out the success of the Colorado program, she compared that figure to a national average of only 26 percent of medical students doing rural rotations.

The number of medical student rotations in rural Colorado has increased from 51 during the 1978-79 academic year to 150 during 1981-82 and 180 estimated for the current year.

How physicians benefit from preceptorships

What is to be gained by the physicians who act as preceptors for the students?

According to Kenneth Deagman, MD, an internist in Kremmling, "It's enjoyable. If a doctor enjoys teaching, I would recommend it."

In a survey taken early in the life of the SEARCH program, nearly 75 percent of rural physicians in areas of medical service said contact with medical students was important to them.

"The students carry what they learn in the classroom into the field," Mr. Guthmann said. "They keep the health care professional up to date on what's going on in the medical center, as well as giving them an opportunity to teach their own skills to the students. It's a reciprocal relationship."

Any overview of the value of the rural preceptorship program would be remiss without attention to the effect it has on the patients with whom the students come in contact. According to the SEARCH study report, "Patients seem to enjoy the presence of students... Patients view students as evidence that their physician is highly-valued by the medical community."

The SEARCH Program benefits rural Colorado.

Continuing education comes to rural Colorado

The preceptorship program addresses the shortage of health manpower in rural areas by looking toward the future and attempting to effect a change in physician practice patterns. The second facet of the SEARCH program, its continuing education activities, has a more immediate goal: to help retain the health care providers already in the rural areas.

The AHEC offices act as intermediaries in providing the area health care professionals with the information they need to stay current in their field.

"Physicians come to us and say, 'We need information on such-and-such a topic,' " explained Mr. Guthmann. When enough health care providers are interested in a subject to justify formulating a program, the AHEC locates a qualified speaker, organizes and implements the program. Speakers come from Colorado and other states. Fees are charged at a rate that will cover costs and generate a certain amount of revenue, a requirement mandated by the state appropriation for the SEARCH program.

"If it weren't for AHEC," Mr. Guthmann stressed, the health providers in the Centennial AHEC in northeast Colorado "wouldn't be receiving the educational programs. High-quality, low-cost programs that they would otherwise have to travel very far to attend." "If we can take the speaker and go out to the rural communities, it's much more cost-effective."

And, of course, with a ratio of one physician to thousands of people, that one physician can't afford to leave his practice for any length of time.

The bottom line in evaluating any program is results. Has the SEARCH/AHEC program made progress in alleviating the maldistribution of health care manpower in rural areas?

Even after the first two years of the program's operation, the data were encouraging. The retention rate for rural physicians who served as preceptors was significantly higher than for rural physicians who did not serve as preceptors.

Because of the seven-year medical education pipeline from admission to actual practice choice, it is too early to draw direct conclusions about the practice location choices of students who have spent rural rotations. However, residency location choices by CU medical students make a positive statement about the influence of the program. Of the class of 1979, only 24.6 percent chose Colorado residencies. In 1981, the second year of extensive student participation in the program, 45.9 percent of the graduating class chose Colorado sites for their residencies.

If the effort continues to succeed, the beneficiaries will be Colorado's rural and small-town population who still depend on their community physician.

A Study of Family Practice Needs in Rural Colorado

George E. Fryer, Jr., MA, MSW; Larry A. Green, MD; Richard D. Krugman, MD; Michael P. Weissberg, MD

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Abstract

This study assessed physician manpower needs in rural Colorado and found that many areas still lack enough physicians. The results of this study are compatible with the Rand analysis of communities of at least 2500 persons, but argue for use of a different unit of analysis to assess the need for additional physicians in sparsely-settled rural areas. Census county divisions (CCDs) or a similar geopolitical unit should be considered as a rational service area for rural physicians.

The population to primary care physician ration in CCDs with no community of at least 2500 population in Colorado was 3489:1, an unfavorable ratio documenting the severity of medical underservice for the 212,822 persons residing in these rural areas. The primary care physicians practicing in these CCDs spent 51.2 hours per week in direct patient care and more than half the communities with a physician were served by more than one physician. These practices are apparently busy and viable because the communities in which they are located function as centers of medical service for larger geographic areas. Family physicians and general practitioners remain the almost sole providers of health care to the inhabitants of Colorado's most isolated rural areas.

Introduction

Since the 1970 publication of the Carnegie Council on Higher Education in Medicine and Dentistry report[1] which suggested the existence of maldistribution of health manpower resources in this country, the U.S. Congress and state legislatures have funded programs to correct the problem of inaccessibility to health care services for millions of Americans. Both urban and rural residents have been subject to the effect of the geographic or practice specialty maldistribution of physicians. However, the degree to which the population of Colorado and the nation now suffer from medical underservice has become a matter of considerable controversy, based in part upon dissimilar results of studies using two different needs assessment methods.

One method uses the county and county, census and civil divisions and districts as the major geopolitical units of analysis and need is predicated on primary care physician to population ratios. This method is the cornerstone of the process through which health manpower shortage and medically-underserved area designations are decided by the federal government. The application of this model was generally uncontested during the last decade, but more recently the findings of a Rand Corporation study[2] using other methods contradict results consistently attained employing the federal methodology, and question its validity. In their examination of physician distribution throughout Colorado and 22 other states, Rand focused on individual communities which were categorized by population. In 1979, virtually every community with as many as 2500 residents was served by a non-federal physician, whereas a later Rand analysis conducted in several other states, further documented the accessibility of Americans to medical care.[3] The services of certain highly specialized physicians were in short supply, and geographic areas such as the Great Plains states had relatively fewer physicians. But even in the most remote rural regions of the country, physical distance and driving time to the office of the nearest physician was found to be acceptable. This study, however, identifies and describes a significantly medically underserved population, and discusses the contribution of family physicians and general practitioners to meeting the health care needs of this underserved population.

Methods

This analysis began by extending

certain aspects of the Rand study to communities of less than 2500. Population data from the 1980 U.S. Census were obtained for Colorado's county census divisions and places. A "place" is either an incorporated town irrespective of population or a "Census Designated Place" (CDP) which is an unincorporated population center of at least 1000 inhabitants.

Information about the physicians practicing in Colorado was derived from the physician film compiled by the Colorado Department of Health in accordance with its Cooperative Health Statistics System (CHSS) survey contract with the National Center for Health Statistics. This survey, conducted in 1980 in conjunction with physician relicensure, was cosponsored by the Colorado Board of Medical Examiners, State Health Department and the University of Colorado School of Medicine. The accuracy of the data base was verified as previously described.[4]

Results and Discussion

There were 206 "places" of fewer than 2500 residents in Colorado in 1980, 152 of which were located outside Standard Metropolitan Statistical Areas (SMSAs). The population of the 152 rural communities which are discussed in this paper was 103,426, an average of 681 per town.

The 152 communities were categorized by population increments, and physician distribution in each category is depicted in the table following this article. Figure 1 confirms the consistency of these findings with those of the Rand study. A consistent curvilinear relationship exists between community population and the presence of a physician, even when there are a small number of towns in the population category, e.g., only 18 towns of 1501 to 2500 residents.

However, the 103,426 Coloradoans residing in these 152 "places" represent only 31.8 percent of the 325,248 people living in Colorado's non-SMSA areas. The remaining 221,822 people (68.2 percent) inhabit areas outside rural communities. We believe that a geographic unit of analysis larger than "town" is required to conduct a meaningful assessment of the health care needs of rural residents. The Census County Division (CCD) is available as a unit of analysis. The U.S. Census Bureau defines the CCD in Colorado and 19 other states as "designed to represent community areas focused on trading centers, or to represent major land use areas, and to have visible, permanent and easily-described boundaries."[5] As such, the CCD affords a logical service area for primary care medical practices and the results of this study support this concept.[1] Of the 152 towns in rural Colorado, only 19 were located in a CCD in which there was a town of more than 2500 people.

There are 212,822 people inhabiting CCDs in Colorado with no place of more than 2500 people. Sixty-one primary care physicians practice in these CCD divisions. The population to primary care physician ratio of 3489:1 is insignificantly different from the 3500:1 criterion used to designate a primary health manpower shortage area.[4] The derived ratio must be adjusted to account for the facts that not every physician practices full time; that these are areas of high rates of migrancy, seasonal tourism and infant mortality; and that large numbers of elderly people reside in these areas. Such an adjustment would undoubtedly show that these 212,822 people, taken collectively, would be considered medically underserved if they lived in a single, large, contiguous area. Because only 91,052 people live in the towns of the same CCDs, the severity of the problem has been somewhat obscured.[5] Deletion of the physician-rich Vail-area CCD, in which a famous ski resort is located, would alter this ratio dramatically and unfavorably.

Factors which may contribute to the further deterioration of this problem include the following. One, although the percentage of Colorado's population not living in towns of at least 2500 people diminished from 21.5 to 19.4 percent from 1970 to 1980, these figures mask the fact that both the state's population and this special population increased during this decade. Two hundred six of Colorado's 291 towns are now populated by fewer than 2500

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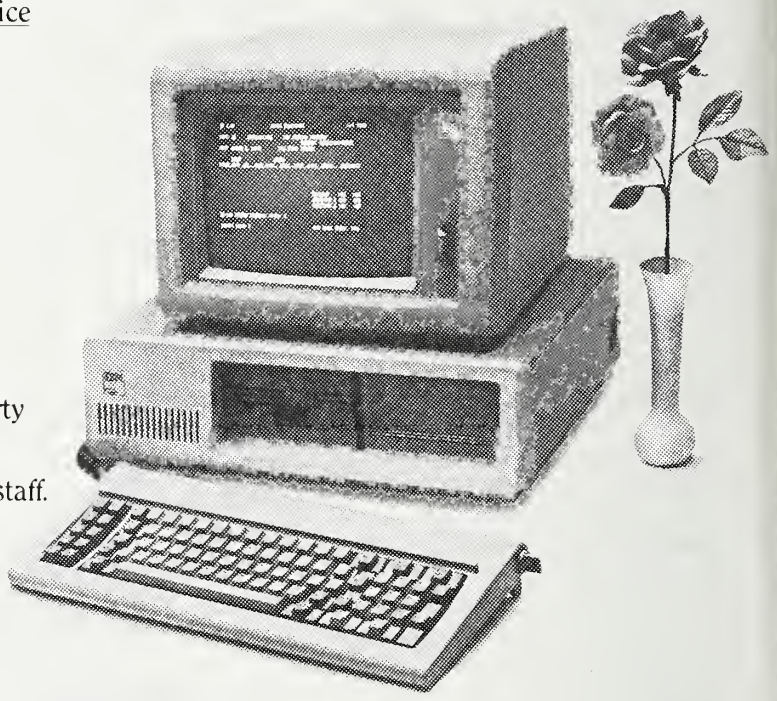
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people.

Two, certificate-of-need legislation has made unlikely any expansion in the number of general hospitals in these more sparsely populated rural areas. The presence of one of these facilities for referral and admission of patients reduces markedly the minimum rate of penetration (proportion of residents of a service area that is active in the physician's practice)[6] of a population of specified size required to sustain a physician practice. There were physicians in 15 of the 16 towns with general hospitals. Only 30 of the other 136 communities studied here were served by physicians.

Three, Rand found that family physicians and general practitioners were members of one of only two specialties (neurology being the other) which served a smaller percentage of towns of 2500 to 5000 people in 1980 than it had in 1970. Increases in other primary care specialties in these towns, however, were shown to be substantial. However, just six of the 61 primary care physicians practicing in the 152 communities in this state of fewer than 2500 people were not family physicians or general practitioners. Obviously, limiting the numbers of family and general physicians could be expected to have a detrimental impact on the accessibility of primary care to the residents of these areas, who depend upon their services.

Additional validity of the CCD as a unit of analysis is derived by its usefulness in explaining the unexpected viability of small-town physician practices. Physicians worked in 45 (29.6 percent) of the 152 places in Colorado, in spite of the fact that the average population of these 45 towns was only 1237. There were 91 non-federal physicians practicing in these 45 towns (2.02 per town). Communities with populations believed insufficient to sustain a single practice were frequently the site of offices of more than one physician. Twenty-four of the 45 places (53.3 percent) which had a physician, had more than one, and these were usually not part-time practices. The primary care providers reported spending an average of 51.2 hours per week in the delivery of direct patient care. This figure is well above the average for Colorado physicians. These practices appeared to be viable and very busy.

Table: Nonfederal Physicians in Colorado Communities of Less than 2500 in 1980

Population	Communities	Communities with Physician	Percentage of Communities with Physician
1–500	74	5	6.8%
501–1000	44	14	31.8%
1001–1500	15	10	66.7%
1501–2000	10	8	80.0%
2001–2500	8	8	100.0%

This superficially surprising phenomenon of practice viability can be explained by looking at the larger geographic area, confirming an important insight of the Rand analysts: "Towns of the same size that differ in the number of people living around them can be treated as having different populations."[2] For towns of substantial population, for which the number of people living in surrounding areas is small in relation to the town population, discriminant treatment may not be important, but for very small communities with surrounding areas populated by many more people than live in the town, broader geographic perspective is imperative.

Family physicians and general practitioners accounted for 90.2 percent of the primary care physician manpower in these most isolated regions of Colorado. Family physicians are less dependent upon large age-specific patient populations than are non-primary care specialists. Family physicians and general practitioners are probably the most valuable single manpower resource in meeting the health care needs of rural residents. The large number of physician visits and long

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Because as physicians we see first hand the human destruction resulting from motor vehicle collisions, we ask that you assume a leadership role and support us in the effort to prevent traffic deaths and injuries in Colorado.

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Denis Elo, M.D.
Chairman
Colorado Seat Belt Coalition

W. Gerald Rainer, M.D.
President
Colorado Medical Society

hours spent in direct patient care[7,8] is another factor which favors them in the role of sole medical care provider in a region. It has been predicted that the productivity of rural physicians will continue to exceed significantly that of other primary care physicians in future years.[9] The results of this study suggest that family physicians and general practitioners recognized the concept of "rational service area" in that they frequently established practices in towns in which a physician's office was already located, although the town was not large enough to support more than one physician.

The willingness of family physicians and general practitioners to spend more time than other physicians in direct patient care has compensated partially for the scarcity of health care providers. The reduction or elimination of family physicians and general practitioners' services for rural Coloradans would leave them virtually without physician care.

Many rural areas lack enough physicians.

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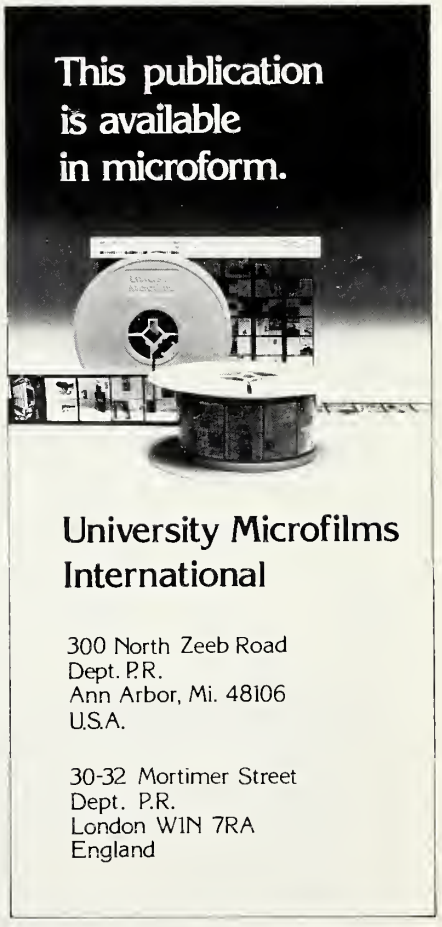
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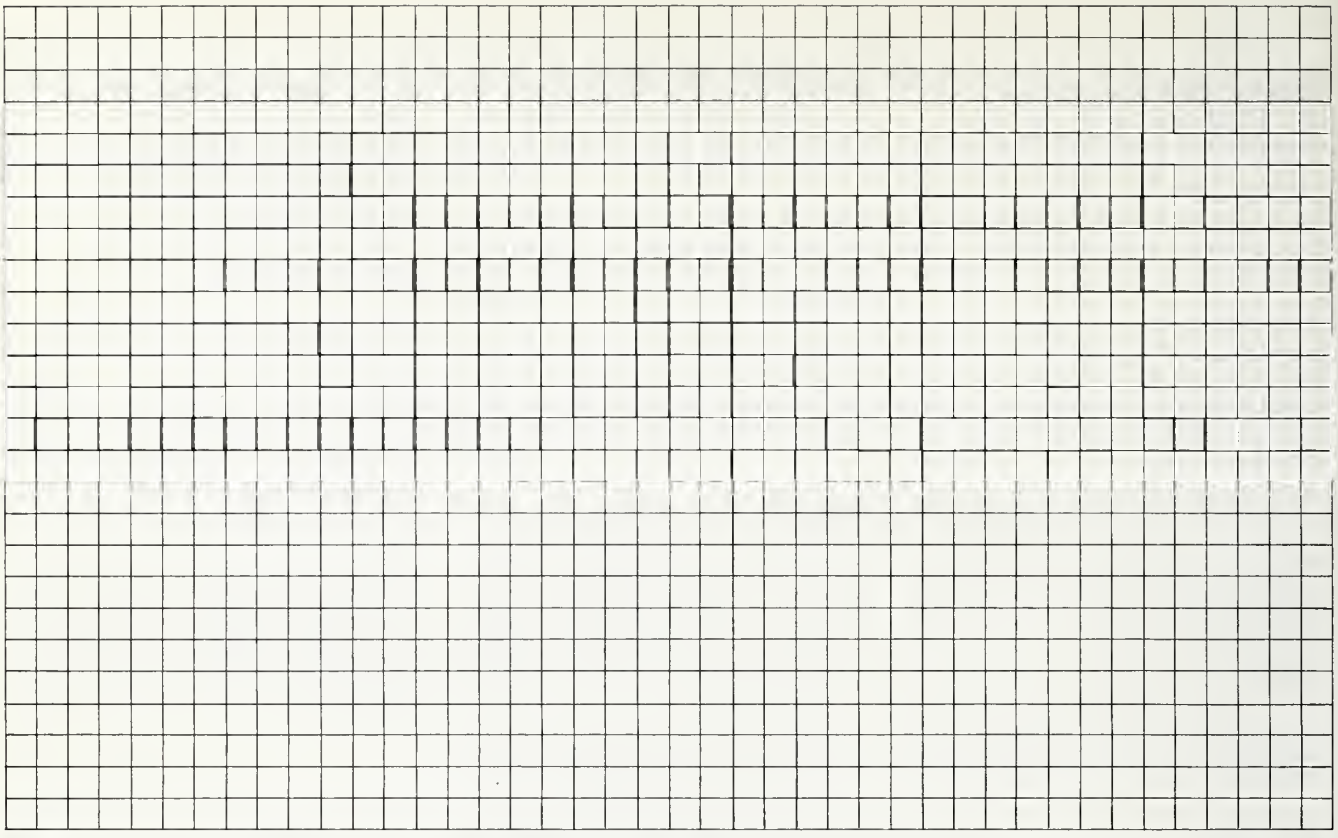
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